

Frank Edelblut  
Commissioner



Jeffrey Meyers  
Commissioner

STATE OF NEW HAMPSHIRE

December 1, 2017

His Excellency, Governor Christopher T. Sununu  
and the Honorable Executive Council  
State House  
Concord, NH 03301

Dear Governor Sununu and Executive Councilors:

We are pleased to deliver to you *Implementing a System of Care for Children's Behavioral Health in New Hampshire: Year 2 Report*, pursuant to 135-F:6. Senate Bill 534, passed in June of 2016, directs the Department of Health and Human Services and the Department of Education to develop a comprehensive system of care for children's behavioral health services. A steering committee comprised of over a dozen individuals with expertise in children's behavioral health has convened numerous times over the past two months to discuss the formulation of this report. With representatives from our departments as well as public school districts, community mental health centers, and advocacy groups in the state, our work has been informed by a diverse group of stakeholders, and we wish to thank them for their invaluable contributions. Additionally, the Endowment for Health has funded the Vulnerable Families Research Program at the Carsey School of Public Policy at the University of New Hampshire to provide technical assistance.

This report builds off of last year's report to estimate the expenditures associated with children's behavioral health services in the State and compare these estimates to the previous year's expenditures. We also assess the ways in which our behavioral health services are consistent with a system of care approach and highlight changes made and some anticipated changes to come that will allow for continual improvement of these services. Additionally, in this year's report we start to examine gaps in the continuum of care for children's behavioral health in New Hampshire and discuss what changes at the federal, state, and department level need to occur to effect change.

As this report represents the second of four annual reports required by RSA 135-F, we acknowledge that systemic improvement efforts will be ongoing.

We look forward to continued support from the State as we work towards ensuring the behavioral health of children in New Hampshire.

Respectfully,

Handwritten signature of Jeffrey Meyers in blue ink.

Jeffrey Meyers  
Commissioner  
NH Department of Health and Human Services

Handwritten signature of Frank Edelblut in black ink.

Frank Edelblut  
Commissioner  
NH Department of Education

Enclosure

cc: The Honorable Gene Chandler, Speaker, NH House of Representatives  
The Honorable Chuck W. Morse, President, NH State Senate  
The Honorable Neal M. Kurk, Chair, House Finance Committee  
The Honorable Gary Daniels, Chair, Senate Finance Committee  
The Honorable Rick M. Ladd, Chair, House Education Committee  
The Honorable John Reagan, Chair, Senate Education Committee  
The Honorable Frank R. Kotowski, Chair, House Health, Human Services & Elderly Affairs Committee  
The Honorable Jeb Bradley, Chair, Senate Health and Human Services Committee

An Act to Implement a System of Care for  
Children's Behavioral Health  
in New Hampshire

Year 2 Report

December 1, 2017

## Executive Summary

In May 2016, the New Hampshire Legislature passed and the Governor signed Senate Bill 534-FN (which established the development of a comprehensive system of care for children's behavioral health services in the state. In December of 2016, a [Year 1 Report](#) was issued, which described initial progress towards implementing a system of care as defined by this legislation. In fulfilling the statutory requirements, this Year 2 Report expands on this earlier work and outlines continued progress towards a system of care for children's behavioral health services. In the past year there have been important incremental improvements to the children's behavioral health system of care, including: the expansion of the Medicaid to Schools program; the 2017-2018 state budget including funding for a new Medicaid benefit that will allow the state to expand the provision of high fidelity wrap services to children with behavioral health needs, paving the way for further integration of high fidelity wrap services beyond the FAST Forward program; the inclusion of children in the forthcoming 10-year plan for mental health services; the expansion of the FAST Forward program to include eligible children and youth from the Division of Children, Youth and Families systems, and; the continued expansion of school-based behavioral health services through the Office of Substance Abuse and Mental Health Service Administration (SAMHSA) grants, and numerous other advances.

Work remains in order to provide a robust system of care. The impact of the opioid crisis has taken a significant toll on New Hampshire's children and families, impacting all child-serving systems. Adverse childhood experiences can have life-long implications to children's health and well-being, and investments in this area can mitigate the impact such trauma has on the brain development of children. Additionally, while the number of children waiting to access acute inpatient psychiatric services at New Hampshire Hospital fluctuates, the fact remains that children are left waiting in hospital emergency rooms before receiving services. Access to community-based mental health and substance use treatment services is also a statewide challenge, as most Community Mental Health Centers have long waiting lists for services. Access challenges are exacerbated by workforce shortages and high staff turnover.

This report begins with an examination of behavioral health expenditures in the state, detailing over \$120 million going towards these services, or roughly \$20 million more than the previous state fiscal year. This increase in overall expenditures is largely due to additional spending captured within the category of General Medicaid expenditures and, in this Year 2 report, we provide a more nuanced picture of the services that fall under this category. Specifically, the net cast was expanded to include all encounters and claims, regardless of procedure, as long as the principal diagnosis was behavioral health-related. However, limitations in data systems, particularly with respect to how behavioral health services are implemented and catalogued in schools, precludes a more confident examination of expenditures.

This report also details the ways in which behavioral health services in New Hampshire are consistent with a system of care and the areas where services fall short. In general, there are pockets of services and particular programs that do provide effective services, but there continues to be a lack of access for the majority of children with intensive behavioral health needs. While the FAST Forward program has been an important and effective expansion of the system of care, the program is not available state-wide and only serves a small portion of the children who would benefit from high fidelity wraparound services.

There are a number of gaps in behavioral health services in New Hampshire. For instance, the three mobile crisis units already implemented in New Hampshire have been focused on adults, although at least two will serve children and youth when called; by infusing this work with youth-based approaches to assist youth and families in crisis, the effectiveness of these mobile crises units could be improved. The lack of sub-acute treatment options represents another gap in care, driving too many children towards services that are either too restrictive or not intense enough. This report also elevates concerns around early childhood education options, telehealth access, and transitional services.

The New Hampshire Departments of Health and Human Services and Education have completed the required interagency agreement, which is included in the appendices of this report. The agreement represents a significant step forward in the collaboration of the two Departments in implementing a system of care. However, it is important to recognize that considerable efforts must still be made. Specifically, there must be advances in the use of data to better understand how behavioral health services are coordinated and implemented around the state, to inform state efforts at ensuring the behavioral health workforce effectively responds to need, and to help identify the practices that result in fair and positive outcomes across New Hampshire.

In the face of continued challenges and uncertain times for many families in New Hampshire, promoting the integration of behavioral health and physical health as well as providing critical social supports for our children remains vitally important. This report outlines much of the relevant work already being conducted in the state, detailing how the Departments of Health and Human Services and Education have improved alignment of children's behavioral health services with a system of care approach. And, in making recommendations as to how and where practices should change and services should be improved, it offers important guidance for expanding this work in the coming years.

## I. Requirements and Organization

Per Chapter 135-F:6 of An Act to Implement a System of Care for Children's Behavioral Health in New Hampshire, there are four elements included in the Year 1 report that must also be included in the Year 2 report (items A through D below). In addition, there are four new elements that must be included in the Year 2 report (items E through H below).

- A. The total cost of children's behavioral health services.
- B. The extent to which the state's behavioral health service systems are consistent with a system of care.
- C. A description of any actual or planned changes in department policy or practice or developments external to the departments that will affect implementation of a system of care.
- D. Any other available information relevant to progress toward full implementation of a system of care.
- E. A summary of the interagency agreement between the departments required by RSA 135-F:7.
- F. Identification of those actions which will be required to maximize federal and private insurance funding participation in the system of care, along with target dates for completion.
- G. Identification of changes to statutes, administrative rules, policies, practices, and managed care and provider contracts which will be necessary to fully implement the system of care.
- H. Identification of significant gaps in the array of children's behavioral health services, along with a description of plans to close those gaps.

Unlike the Year 1 Report, which detailed findings along major program areas, this Year 2 Report is organized by topical area as to emphasize the holistic and integrated nature of this work. To simplify the presentation of this report's findings, we collapse the eight statutory requirements into five topical areas:

- Expenditures
- Consistency with a System of Care (including an identification of significant gaps, along with a description of plans to close those gaps)
- Changes in Policy and Practice
- Maximizing Funding
- Summary of the Interagency Agreement

## II. Limitations

Much like the Year 1 Report, the primary limitation of this report relates to the estimation of the “cost” of child behavioral health services in the state. We again interpret “cost” rather narrowly, defining it as the sum of all state expenditures that have a primary focus on the promotion of children’s behavioral health. Specifically, we estimate fiscal year expenditures, and note that this might not capture more periodic investments.

Additionally, these expenditures illustrate only what was spent, not what the actual costs of services would be if made fully available. Perhaps more importantly, such a definition of “cost” does not entail those human and societal costs that result from unmet behavioral needs. Ultimately, such an inquiry is beyond the scope of this report.

Even when examining only fiscal year expenditures, limitations remain. The use of multiple departmental data and reporting systems require us to present State Fiscal Year (SFY)2016 expenditures at some points for some services, and SFY 2017 expenditures for others. Specifically, DHHS expenditures typically refer to SFY 2016 while DOE expenditures are typically reflective of SFY 2017.

Each table indicates the reference year for estimates presented therein. Additionally, the detailed expenditures presented in this report reflect state and federal funding exclusively, as these are the only levels at which such fiscal data are readily available. School districts and communities do receive funding from other sources, such as local taxes, grants, and contributions from local businesses and philanthropic organizations. The total spending on child behavioral health services from these local sources is assumed to be substantial, but ultimately cannot be included here. Though efforts have been made in Year 2 to expand our understanding of how such data could be collected in the future, we are currently still unable to include these costs.

## III. Report Findings

### A. Expenditures

The 2016 report identified over \$100 million in expenditures towards behavioral health service. Expenditures for 2017 are estimated to have increased slightly, to more than \$120 million. Here we present expenditures across four areas of DHHS including the Division of Children, Youth and Families (DCYF), Division of Behavioral Health (DBH), and Bureau of Developmental Services (BDS) and Medicaid. Also presented are behavioral health expenditures within the Titles I, II, and IVb programs, which are meant to capture some of the overall behavioral health expenditures within schools. We provide side-by-side comparisons for 2016 and 2017, and compute year-to-year change in expenditures across the categories captured. Though small changes from one year to the next are expected and may be due to statistical noise, tracking change each year moving forward can establish patterns and demonstrate those costs that are rising fastest, remaining stable, and declining. See Appendices A through E for these data.

Expenditures within DHHS total nearly \$120 million, which amounts to roughly \$20 million more than last year. Behavioral health service funding within DCYF (Appendix A) is about \$39, which is roughly 10 percent more than last year. A much greater increase was recorded within BDS (Appendix B): year 2 expenditures totaled nearly \$83 million, compared to only \$61 million in year 1. Much of this increase is due to more expenditures being captured under the General Medicaid category. Specifically, all encounters and claims we included, regardless of the procedure code, as long as a principal behavioral health diagnosis was attached. Appendix C reveals that Community Mental Health Centers (CMHCs) account for nearly \$25 million in expenditures, providing the majority of outpatient behavioral health support in the New Hampshire. However, we also identify nearly \$16 million in Medicaid funds that supports private Medicaid providers, which is an important service delivery system for children's behavioral health in New Hampshire. Although the \$67 million spent through General Medicaid is slightly more than half of all the children's behavioral health expenditures identified in the state, it amounts to less than 4 percent of the total Medicaid spending in New Hampshire. Appendix D shows that spending in BDS has fallen by roughly half, from about \$480,000 in 2015 to roughly 240,000 in 2016.

In addition to the DHHS funding described here, the DHHS, Bureau for Children's Behavioral Health was the recipient of a State Youth Treatment Planning Grant, which provided funding to develop a plan to enhance the publicly funded substance use treatment system in NH with practices and approaches to better engage youth and their families in treatment and keep them in treatment longer. Most recently the DHHS was awarded a four-year implementation grant to now implement the three-year plan. This is a four-year grant, bringing an additional \$760,000 to support this work.

In Appendix E we report on school-based behavioral health expenditures through Titles I, II and IVb, which are federal grant programs purposed for assistance to Local Education Agencies (LEAs) with high numbers/rates of low-income students, programs to support high quality teachers and principals, and 21<sup>st</sup> century community learning centers, respectively. The DOE did not repeat the survey methodology used to create estimates from last year's report. Rather, changes in overall Titles I, II and IVb expenditures were used to estimate the behavioral health expenditures within these areas. Overall, we see that the school-based spending on behavioral health services, as defined and estimated in this manner, are consistent between SFY 2016 and SFY 2017. Current capacity limitations and reporting systems preclude more precise estimates. However, in future years the DOE intends to more accurately capture Title expenditures directed at children's behavioral health services by adapting reporting systems.

We also cannot capture school-based expenditures that are made at the local level, as these data are not systematically captured by the state. For instance, schools may provide behavioral health services in the form of individual and group counseling, substance misuse prevention programming, and special education services to students with behavioral health challenges. A case study was conducted with five New Hampshire school districts to better understand how such spending is conceptualized and organized at the local level. The report, which is included in Appendix F, highlights key findings along these lines and makes recommendations as to how local spending can be systematically estimated by the state.

In addition to federal funding via title programs and local funding, nine New Hampshire School Districts are receiving federal funding from New Hampshire Department of Education to address children's mental health issues. The New Hampshire Department of Education was awarded funding in the following areas:

- Safe Schools and Healthy Students State Planning Project from the U.S. Department of Health and Human Services, Office of Substance Abuse and Mental Health Service Administration (SAMHSA). This project is in partnership with three LEAs: Concord, Laconia, and Rochester School Districts. The four-year grant is designed to improve the climate and safety of schools while promoting the emotional well-being of students by enhancing behavioral health supports in the school and at home with linkages to community resources.
- Project Advancing Wellness and Resilience in Education (AWARE), also from SAMHSA. Project AWARE encourages the creation and sustainability of local resources that can address mental health and substance abuse issues. It promotes communication and organizational relationships that greatly increase the likelihood that mental health issues will be dealt with appropriately, and ultimately the most positive possible outcomes. This five-year grant takes place in partnership with parents/caregivers in three places: Berlin Public Schools, Franklin School District, and SAU #7.
- System of care expansion and sustainability called FAST Forward 2020, also from SAMHSA. System of care is a term used to describe a coordinated approach for supporting children, youth, and their families. This infrastructure will expand the array of supports for all children including those with diagnosable serious mental and behavioral health disorders. The grant will create regional systems of care, build strong collaboration between schools, families and youth, and community-based behavioral health providers, and use an evidence-based framework to deliver high quality support and services. This four-year grant works in partnership with Laconia, Franklin, Winnisquam Regional, Berlin, White Mountain Regional School Districts and SAU #7.

#### B. Consistency with a System of Care

The characteristics of a system of care are clearly outlined in RSA 135-F and in Table 1. Here we describe the extent to which behavioral health services in the state are consistent with a system of care approach according to each of these eleven characteristics. Note that this alignment speaks to the overall system of care within New Hampshire; some individual efforts illustrate a system of care approach on a smaller scale. After describing consistency with a system of care, we identify any significant gaps in the array of children's behavioral health services, and describe plans to close such gaps. Included within this table are the results of a survey conducted by DHHS regarding alignment with a system of care. This survey, which was developed by national experts in

the field to determine alignment with a system of care approach, was completed by 43 professionals from CMHCs and one Care Management Entity organization in New Hampshire. Note that these results are not generalizable to the entire state, as this survey did not capture family and child perspectives. However, the results are illustrative from the provider perspective, and offer some useful indicators as to system of care alignment within New Hampshire.

<b>Table 1: Characteristics of a System of Care and New Hampshire Service Alignment</b>	
<b>System of Care Characteristic</b>	<b>Summary of Alignment</b>
(a) A comprehensive behavioral health program with a flexible benefit package that includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.	<p>Services are not comprehensive and are provided in a deficit-based model with a lack of support (system wide and financial) to implement evidence-based practices. Families face delays in accessing services, and services are disjointed. Most services in the children’s behavioral health system are community based. There are few options for non-community based services in New Hampshire at this time. Overall, the continuum of care is not complete.</p> <p>The area of alignment in most need of attention relates to flexibility of services and service provision. This area is lacking mostly due to regulations regarding funding streams but also due to standards and rules that have not changed for many years. Current opportunities to increase the service array and its flexibility and ability to better meet a child and family’s needs include;</p> <ul style="list-style-type: none"> <li>• Expansion of the Medicaid to Schools program relative to SB 235,</li> <li>• House Bill 400 which includes provisions for development of a ten-year mental health plan to include children and youth,</li> <li>• Develop a Children’s Medicaid Benefit via a Medicaid State Plan Amendment relative to House Bill 517.</li> </ul> <p>Survey results indicate that the majority of respondents believe that a comprehensive array of supports is at least moderately implemented in New Hampshire.</p>
(b) An absence of significant gaps in services and barriers to access services.	Gaps in services is an area of improvement for NH’s system. Results from the DHHS survey of CMHCs and a community partner reveal a number of areas where gaps may exist in New Hampshire. For instance, the majority of respondents believe that substance use residential treatment, substance use treatment, transportation, day services, respite services, and mobile crises services are only somewhat or not at all available/implemented. Specifically, mid-range services are most lacking. Gaps identified in the system that are of particular importance will be discussed further later in this report.
(c) Community-based care planning and service delivery, including services and supports for children from birth	Work in this area has not reached maximum penetration. There has been progress made in many communities with the implementation of the pyramid model which is the model of a multi-tiered system of support designed for young children in early learning and child care settings. Additionally, behavioral health support for early learning and child care settings is available from funding by DCYF and DOE, which contract organizations assisting in these settings to support young children.

<p>through early childhood.</p>	<p>NH Pyramid Model provides training, technical assistance and support to state leaders from public and private organizations who are concerned with the social-emotional development of our state's young children. The Pyramid Model is a Positive Behavioral Intervention and Support (PBIS) framework that uses systems thinking and implementation science to promote evidence-based practices. The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children was created to help early educators build skills for supporting nurturing and responsive caregiving, create learning environments, provide targeted social-emotional skills, and support children with challenging behavior.</p> <p>The DOE, Office of Student Wellness (OSW) Early Childhood Work Group supported the roll out of the early childhood social and emotional screening, ASQ-SE, for all incoming kindergarteners at the six LEA pilot sites and additional sites throughout the state. The group has also developed a partnership with Watch Me Grow to work toward increasing the number of preschoolers screened across the state. Activities related to early childhood development were also aligned with the efforts of SPARK NH, New Hampshire's Governor appointed early childhood advisory council. In addition, the DOE has sponsored over 20 individuals to be credentialed in Early Childhood Family Mental Health.</p> <p>Work around aligning eligibility criteria in CMHCs for this age population will begin in the coming year to address this area of alignment.</p> <p>Survey results indicate that the majority of respondents believe that a community-based approach is at least moderately implemented in New Hampshire.</p>
<p>(d) Service planning and implementation based on the needs and preferences of the child or youth and his or her family which places an emphasis on early identification, prevention, and treatment and uses an individualized wraparound approach for children with complex needs.</p>	<p>Most child-serving programs associated with the DHHS, at a minimum, employ a person-centered service planning method as required by Medicaid regulations.</p> <p>Moving program areas and regulations to a family and youth driven service planning method has begun by the implementation and expansion of NH Wraparound in the following areas:</p> <ul style="list-style-type: none"> <li>• FAST Forward program</li> <li>• Monadnock Region System of Care</li> <li>• Department of Education System of Care</li> <li>• Integrated Delivery Network region 2 Enhanced Care Coordination project, associated with the 1115 Medicaid Waiver Work.</li> <li>• Center for Life Management CMHC integration of NH Wraparound with it's children ACT teams.</li> </ul> <p>Areas of further expansion and improvement will be further identified and prioritized over the coming year.</p> <p>Overall, there is not universal adoption or funding for a Multi-Tiered System of Support (MTSS) in New Hampshire public schools. There are pockets of excellence in the state. Schools understand the need to have families at the center of the care but implementing the system of care principles is new for schools and it will take time to</p>

	<p>change the schools culture to adopt such principles. Unfortunately, the state does not have data as to the proportion of schools implementing a MTSS approach.</p>
<p>(e) Services that are family-driven, youth-guided, community-based, and culturally and linguistically competent.</p>	<p>Most child-serving programs associated with the DHHS, at a minimum employ a person-centered service planning method as required by Medicaid regulations.</p> <p>Moving program areas and regulations to a family and youth driven service planning method has begun by the implementation and expansion of New Hampshire Wraparound in the following areas:</p> <ul style="list-style-type: none"> <li>• FAST Forward program including the inclusion of DCYF cases in the FAST Forward programming.</li> <li>• Monadnock Region System of Care</li> <li>• Department of Education System of Care</li> <li>• Integrated Delivery Network region 2 Enhanced Care Coordination project, associated with the 1115 Medicaid Waiver Work.</li> <li>• Center for Life Management CMHC integration of NH Wraparound with its children ACT teams.</li> </ul> <p>DHHS has incorporated requirements regarding CLC competency and alignment with CLAS standards. Additionally, programs and providers associated with DHHS system of care work were encouraged to participate in a CLC self-assessment and improvement work with the assistance of DHHS’s CLC program specialist.</p> <p>DOE has also used the system of care guiding principles in at least 6 other school districts. In addition to help scale-up and sustain this work the DOE has supported the training in Conversations on Culture &amp; Diversity, which is open to the public and promoted across educational communities throughout the state. This 4-hour training provided an opportunity for participants to explore the concepts of culture and diversity as they relate to their own personal cultural identity, beliefs and values and how that influences their practices in education and/or behavioral health. In addition to this training DOE, OSW offers training on Cultural Linguistic Appropriate Services (CLAS) standard. CLAS Standards were developed in 2000 in an effort to guide healthcare organizations to compliance with the federal civil rights laws that require communication assistance (Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990). Between 2010 and 2013, the CLAS standards went through an enhancement process. As a result of that process, the definition of health has expanded to include: physical, behavioral, social, and spiritual well-being. The Enhanced CLAS Standards are intended for a broad audience including organizations that provide behavioral and mental health services, and community health and prevention. As school districts look to educate and care for the whole-child in New Hampshire, we see ourselves as one of these organizations. The 15 CLAS standards provide guidance which can be understood as one Principal Standard (or overarching goal) and three main themes: 1) Governance, Leadership, and Workforce, 2) Communication and Language Assistance, and 3) Engagement, Continuous Improvement and Accountability.</p>

	<p>DOE, OSW has also a resource page on their website to help schools address cultural competency and CLAS. Video: <a href="https://vimeo.com/140692157">https://vimeo.com/140692157</a></p> <p>Website: <a href="http://www.nhstudentwellness.org/clcresourceguide.html">http://www.nhstudentwellness.org/clcresourceguide.html</a></p> <p>DOE, OSW hosted in 2016 the first annual New Hampshire School Discipline Guidance Conference. In 2017 it was determined that the next step was to provide technical assistance and tools to school administrators to assist them in reviewing their school discipline data, analyze and determine root cause of disparities, in order to create plans to improve discipline practices. The OSW worked with the Mid-Atlantic Equity Consortium to offer two sessions on Successful Approaches to Discipline at New Hampshire’s Educators Summit to meet this need. Additionally, a resource page dedicated to improving school discipline was created on the OSW website (<a href="http://www.nhstudentwellness.org/discipline.html">http://www.nhstudentwellness.org/discipline.html</a>). Areas of further expansion and improvement will be further identified and prioritized over the coming year.</p> <p>Survey results indicate that the majority of respondents believe that a culturally responsive approach is at least moderately implemented in New Hampshire. However, it is worth reiterative that this survey <u>did not capture family and youth perspectives.</u></p>
<p>(f) An efficient balance of local participation and statewide administration.</p>	<p>Most publicly-funded services and supports for children and youth with behavioral health needs are funded through state programming, either by Medicaid, or by grant dollars to support programming in local communities.</p> <p>Local participation is hard to capture and compile as it varies from location and by funder. An example of state and local partnership is the system of care work being done in the Monadnock region and in the school’s participating in the DOE system of care work.</p> <p>Much work is currently supported in schools by local funds. Special education accounts for a significant portion of this spending. Currently there is no systematic way to capture this work, though a recent study on behavioral health expenditures in schools sheds light on how efforts can be made to improve our understanding in this area. In general, relevant data are often available locally, but are not easy to aggregate and examine state-wide under current systems.</p>
<p>(g) Integration of funding streams.</p>	<p>Most funding sources relative to behavioral health have requirements as to what is allowed and what is not allowed. Braiding funding sources for behavioral health programming started under the DHHS’s system of care work by blending funds from Medicaid, state general funds and child welfare grants. This will continue as the FAST Forward program expands to serve children with open DCYF cases, thus bringing in all the applicable funding streams. Efforts have been made on a small scale, but not systems wide. Given the aforementioned challenges around data, it is difficult to achieve consistency with this characteristic of a system of care approach.</p> <p>Much work is currently supported in schools by local funds. Schools often blend and braid funding with both local and federal funds as regulations permit to meet the needs of the children. Currently there is no systematic way to capture this work, though a</p>

	<p>recent study on behavioral health expenditures in schools sheds light on how efforts can be made to improve our understanding in this area.</p>
<p>(h) A performance measurement system for monitoring quality and access.</p>	<p>As program development in this area progresses, the opportunity to collect shared or standard measures across the system will arise. As the FAST Forward programming moves solely to Medicaid funding, the requirements for measurement will be identified within the Medicaid benefit submitted for federal approval. Once approved these indicators will need to be observed over time, and eventually these measures will be incorporated in the data tracking systems of Medicaid managed care companies.</p> <p>As more programming is aligned with a system of care, the same measurements will be applied across systems that are engaged in this programming.</p> <p>DOE has been encouraging school districts (20 to date) to measure their comprehensive mental health using the School Health Assessment and Performance Evaluation (SHAPE) system. SHAPE is a free, private, web-based portal that offers a virtual work space for school mental health teams to document, track, and advance quality and sustainability goals. SHAPE allows schools to invite any school- or community-based team members to the school’s SHAPE account, where they can work as a coordinated team to assess and document the mental health services and supports provided to its students.</p> <p>Survey results indicate that roughly a third of respondents believe that a process for monitoring and measuring quality does not exist New Hampshire, while another third report not knowing. Ultimately, there is not a way to link investments to outcomes in the state.</p>
<p>(i) Accountability for quality, access, and cost.</p>	<p>Accountability for quality, access and cost are all tenets of the Medicaid and Medicaid Managed Care program. The quality of programming aligned with a system of care are using national quality measures such as fidelity tools, including participant satisfaction tools as well as cost measures such a service utilization. As programming expands, the same tools will be used to monitor quality, access and cost.</p> <p>The use of the Child and Adolescent Needs and Strengths assessment tool is being implemented into the FAST Forward and FAST Forward 2020 programming as it expands. A member of the Bureau for Children’s Behavioral Health is now a certified trainer to ensure all New Hampshire Wraparound Coordinators are trained in this assessment tool. This assessment tool identifies each child’s strengths and needs and helps to inform the plan of care as well as tracking progress overtime at the individual level.</p>
<p>(j) Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.</p>	<p>Workforce training across systems is an area for improvement. Training and coaching for evidences based practice, wraparound and other effective practices are typically left to each provider. There is not a central place or hub for behavioral health training across systems.</p> <p>Some areas of progress include evidenced-based practices being implemented currently through state and grant dollars:</p>

	<ul style="list-style-type: none"> <li>• MATCH</li> <li>• First Episode Psychosis</li> <li>• Trauma-informed approaches</li> <li>• MTSS-B</li> <li>• Mindfulness</li> <li>• Coping Cat</li> <li>• Child parent psychotherapy</li> <li>• Youth Mental Health First Aid</li> <li>• Training for New Hampshire Wraparound</li> <li>• RENEW</li> </ul> <p>In addition, four colleges and universities in the state have received 4-year grants from the US Health Resources Services Administration (HRSA) that focus on the preparation of students to enter behavioral health careers. UNH has received one of the grants that will prepare 116 master’s level social work and occupational therapy students including field placements in integrated behavioral and primary healthcare settings. The Community College in Manchester received one of the grants to prepare Associates degree students in to become Behavioral Health technicians. Plymouth State University received another grant, this one for students in its masters level school psychology and community mental health programs. Finally, Rivier College received a grant to prepare bachelors and master’s level psychiatric nurses. These projects represent a substantial effort to better prepare individuals to enter behavioral health careers serving children, adolescents, and adults.</p>
(k) Effective identification of youth in need of transition services to adult systems.	<p>Transitions from child programming to adult programming can be inefficient and sometimes results in a young adult no longer being eligible for necessary services using the adult eligibility criteria. Adult mental health services require strict mental illness diagnoses, eliminating a large group of children from continued eligibility when they turn 18. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is an option for some, but difficult to access because it requires a prescription from a medical provider. Possible solutions to this challenge include:</p> <ul style="list-style-type: none"> <li>• review of eligibility and waivers in CMHCs</li> <li>• review the effectiveness of the RENEW model in preparing youth to successfully transition to adulthood, which is being implemented by nine of the state’s ten CMHCs mental health centers</li> <li>• an assessment of the potential to engage and leverage NH Vocational Rehabilitation services (part of DOE) to support transition and loss of children’s supports</li> <li>• Protocols for identifying high need youth and young adults in the DCYF system who will need services from the CMHCs are being developed.</li> </ul> <p>Survey results indicate that the majority of respondents believe that appropriate transition services are at least moderately implemented in New Hampshire.</p>

Overall, there is variability in the extent to which children’s behavioral health services are consistent with a system of care in the state. The availability of the full suite

or continuum of care for behavioral health services was considered across age groups and applicable components of a system of care to understand where gaps in services exist. From this analysis DHHS and DOE determined the following services that, if implemented or expanded, would make children’s behavioral health services in the state more consistent with a system of care (see table 2).

Table 2: Significant gaps in the array of children’s behavioral health services, and plans to close those gaps.	
Gap	Description of Gap and Preliminary Plan to Close Gap
Mobile crises units	<p>Mobile Crisis teams are successfully used in other states that align with a system of care (e.g. New Jersey). Creating the ability to respond in moments of real need can begin to identify underlying needs. In turn, this may prevent the use of psychiatric hospitals or other less effective, more expensive services, and reduce caregiver strain.</p> <p>Funding to support mobile crisis units is a barrier to effective services, as emergency response teams can be a costly expense to providers. Three mobile crisis units already implemented in New Hampshire have been focused on adults. By infusing this work with youth-based approaches to assist youth and families in crisis, the work currently conducted within these units will be enhanced.</p>
Early childhood services	<p>Children under age three are not eligible for many community-based services and supports. Although programs do exist, these programs are often regional in nature, and often not aligned with a system of care. An effective crosswalk of the current practices, evidenced-based programs, and eligibility standards for this population is an area of need. Services and supports for young children are limited across New Hampshire to programming such as home visiting and some child care centers or early preschools that are aligned with the pyramid model. A lack of expertise in the diagnosis of emerging mental health disorders in young children is also a concern.</p>
Sub-acute treatment options	<p>The mental health treatment system in NH is comprised mainly of community based services and the few psychiatric acute care hospitals for those that need that level of stabilization. Having sub-acute treatment options available can reduce bottle necks of children and youth in emergency rooms, and of those that are appropriate for discharge from the psychiatric hospital but require further stabilization in a less restrictive setting. Sub-acute treatment options can also provide an alternative to psychiatric hospitalizations for children and youth for whom it may be appropriate. Sub-acute treatment options are designed to provide further stabilization and short-term treatment before discharge back into the community. This treatment option is not intended to provide long term residential care for children.</p>
Telehealth	<p>Although telehealth exists in several capacities, there are areas to be able to expand the use of teletherapies and telehealth in New Hampshire to increase capacity and access to critical services. Use of telehealth is expanding within DHHS programming and funding and this expansion</p>

	can be used to inform expansion into the school environment. Issues around licensing are being addressed in the 1115 waiver work at the DHHS.
Transitional services	Effective programming exists for transitional age youth who are over 18 years old, in limited areas and quantities. However, there is a significant gap in providing transition services to youth who are 16 and 17 and their families that present with very similar needs. Creating a crosswalk for current programming, and examining how to expand services to this population could help to close this gap and create stronger outcomes for many youth.

Additionally, we identify areas in the state that, while not representing gaps in services, are initiatives that should be expanded in order to increase consistency with a system of care approach.

**RENEW (Rehabilitation for Empowerment, Natural Supports, Education and Work).** RENEW is a research-based intervention for transition-age youth and young adults with emotional and behavioral challenges. The RENEW process helps youth develop and pursue a plan to graduate from high school, and move into college and employment, housing, and engage in other needed services. RENEW was installed in 9 of the state’s 10 CMHCs with investments from the Endowment for Health, a Medicaid Balancing Incentive Program grant, and now is sustained by a state block grant funding at a cost of less than \$4,000 per year per center. There is a need, however, to incentivize implementation of RENEW as it is an intensive intervention that requires training and technical assistance if it is to be delivered with fidelity, and it is not available to young adults who age out of the children’s MH system. In FY 2018, the plan is to engage New Hampshire’s Vocational Rehabilitation agency to support the development of a new funding source for RENEW which will allow youth to receive RENEW even if they age out of the CMHC children’s services and Medicaid eligibility.

**Project Linking Actions for Unmet Needs in Children’s Health (LAUNCH).** Project LAUNCH federal initiative funded by SAMHSA, is pioneering new ways to promote young child wellness and increase access to high quality prevention and wellness programs for Manchester area low-income families and their children 0-8 years old in order to improve developmental outcomes. Project LAUNCH NH works to ensure local agencies work together to provide children and families a great start through evidence-based practices and coordinated services. Project LAUNCH has built strong collaborations that have led to the replication of successful services implemented in Manchester and sustainable systems improvements that will last beyond the life of the project. The work of the local Manchester pilot informs the development of a state-wide comprehensive, coordinated, sustainable early childhood system that achieves positive outcomes for young children and families. To achieve its vision that all children flourish and enter school healthy, ready to learn, and able to succeed, Project LAUNCH’s direct service prevention and promotion strategies include:

- Increasing developmental and social-emotional screening in child care and health care settings through ASQ-3 and ASQ:SE2.
- Integrating behavioral health into primary care through the use of community health workers to help families navigate a complex system of supports
- Behavioral support coaching to teachers in early care and education settings to improve teacher practices, promote social-emotional development in children, and address children's challenging behavior using the Pyramid Model.
- Enhancing home visitation through a Community of Practice that brings together staff from disparate home visiting programs to build skills and ensure quality home visiting experiences for families.
- Family strengthening and skill-building through parent education curriculum *Positive Solutions for Families* (Pyramid Model) and parent cafes.
- Trauma-informed responses to mitigate the risks associated with adverse childhood experiences through the Adverse Childhood Experiences Response Team (ACERT).

**FAST Forward Program.** The FAST Forward Program is part of New Hampshire's System of Care which is system designed to serve New Hampshire children, youth, and families experiencing difficulties in day-to-day life due to a severe emotional disturbance (SED) and are at risk for acute psychiatric hospitalization or placement in a residential treatment facility. Built on partnerships among service systems within the DHHS and community-based providers, FAST Forward offers access to individualized services, guided by a strengths-based, wraparound care coordination process.

NH Wraparound Model is central to FAST Forward's system of care strategy for improving children, youth and family outcomes. NH Wraparound is a youth and family-driven care planning and coordination process, delivered by highly trained FAST Forward coordinators (FFCs). Through NH Wraparound, a plan of care focuses on developing and utilizing youth/family strengths, and building natural supports. Plan of Care strategies and services is developed, endorsed, monitored, and improved to meet the identified needs and benchmarks of each youth and their family.

After an analysis conducted by Antioch University of New England, in which their team conducted a pre/post assessment of service utilization, the data helps begin to understand the service and cost impacts FAST Forward's System of Care approach has on New Hampshire state Medicaid expenditures, emergency room use and hospital inpatient utilization. Major findings showed a reduction in overall cost by 28 percent for the youth and families that were evaluated.

With this analysis, the FAST Forward program has expanded to meet the needs of NH children, youth and families. In October 2016, DHHS, Bureau for Children's Behavioral Health, selected NFI North (NFI) as the Care Management Entity for the FAST Forward Program bringing high fidelity wraparound and wraparound components/services to communities across the state. In October 2016, NFI began with 3 full time FAST

Forward Coordinators and by November 2017, now has 7 full time FAST Forward coordinators to date. Between October 1<sup>st</sup>, 2016 and November 13<sup>th</sup>, 2017 FAST Forward has enrolled 73 new children, youth and their families. In that same time period FAST forward has successfully transitioned 40 with a success rate of 50 percent or higher. Success rates are determined based upon the children, youth and family effectively meeting their family vision and team's mission.

With this outcome data, FAST Forward program has expanded to serve a subset of the DCYF, court involved population beginning December 1<sup>st</sup>, 2017. Expanding effective services that utilize a system of care approach, that have positive outcomes are part of the RSA 135-F requirements. FAST Forward is showing positive family and child level outcomes by offering intensive home and community based services to children/youth in a home environment, a wraparound practice approach using NH Wraparound curriculum, and flexible services and service delivery to meet the needs of the child/youth and their caregiver. Identification of populations within DCYF includes: CHINS cases to serve in home or return home after an out of home episode (particularly current D2 cases), pre adoptive cases: at time of identification of and placement in a pre-adoptive home to strengthen the adoption or identify any issues that may be of concern, post adoptive cases: For cases coming back for post adopt services. To help serve this population effectively, NFI has added 1 additional full time FAST Forward Coordinator as of November 13<sup>th</sup>, 2017 and will look at hiring 1 more full time FAST Forward Coordinator to help meet this need area.

Beyond the FAST forward program expansion, both programmatic and working with DCYF populations, DHHS FAST forward program staff has provided technical assistance and program support to several System of Care programs across the state. Monadnock Region System of Care and the Department of Education's System of Care programs have integrated the NH Wraparound Model into their System of Care practice and have worked closely with DHHS FAST Forward in aligning their current models to be consistent with FAST Forward's program and practice.

Additionally, two other organizations have utilized NH Wraparound as a model for Care Coordination. IDN Region 2's Enhanced Care Coordination program housed out of Riverbend Community Mental Health Center is using NH Wraparound as their enhanced care coordination foundation, as well as family and youth peer support and flexible funding to enhance this project and how they work with children and families with intense needs. Riverbend has just started to implement this approach. Additionally, The Center for Life Management has utilized NH Wraparound as a care coordination model as part of their Children's ACT Teams. Center for Life Management is seeing outcomes from their use of NH Wraparound that mirrors the outcomes seen by the FAST Forward program as described above including a reduction in the use of Emergency Services and psychiatric hospitalizations.

Continued expansion of the FAST Forward program and expanded use of the NH Wraparound Model will continue over the next year as DHHS works on the Medicaid benefit associated with FAST Forward programming as described in HB 517.

### C. Changes in Policy and Practice

**Federal statutes, rules, and policies.** At the federal level, changes must be made to ensure adequate funding (e.g., through block and formula grants) and focus on prevention, programs, services, and standards of practice. Medicaid is a primary funder of behavioral health services to children, youth, and young adults. Access to Medicaid through Children's Health Insurance Program (CHIP) is critical to provide services when needed and not just in a crisis, at a much higher cost. Together with Medicaid, CHIP provides a strong base of coverage for children in New Hampshire. Federal funding for CHIP expired September 30, 2017. While New Hampshire has some flexibility to fund the CHIP program into 2018, there are very real concerns regarding Washington's ability to move quickly to refund this essential children's health coverage program, with some 9 million children nation-wide in danger of losing health care.<sup>1</sup> Congress has taken initial steps to extend federal funding for CHIP and there is general agreement on proposed provisions related to CHIP. However, Congress still must complete a number of steps to pass final legislation, and, as part of this process, the House and Senate will need to resolve any differences between their bills and reach agreement on offsets.

**State statutes and rules.** Statutes and rules are being assessed for changes necessary to align practices and encourage programming, services and supports that are aligned with the system of care framework. During the 2017-2018 session, the New Hampshire legislature will be deciding whether to continue Medicaid expansion beyond its current expiration date at the end of 2018. While the majority of uninsured children in NH are eligible for Medicaid or CHIP, access to Medicaid through expansion is critical for families. One of the most effective strategies for states to reach eligible but uninsured children is to put out the welcome mat for the whole family by extending Medicaid coverage to parents and other low-income adults. States that expand Medicaid coverage to more low-income adults not only reduce the number of uninsured children but also boost children and families' economic security and will benefit children by having healthier parents. Additionally, a review of the children behavioral health workforce in New Hampshire identified a number of barriers to sufficient staffing, and outlined strategies that could be employed to address such workforce shortages in the state, such as enhanced training, simplifying licensure and certification requirements, and financial incentives such as increased pay and loan forgiveness. A copy of this literature review may be found in Appendix G.

**Department policies and practices.** In terms of department practices, coordinated funding and programming are needed, as well as consistent policies between school

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<sup>1</sup> Carson, Jessica, "Data Snapshot: Nine Million Publicly Insured Children in the Twelve States Facing Federal CHIP Cutoff by End of Year" (2017). *The Carsey School of Public Policy at the Scholars' Repository*. 321. <http://scholars.unh.edu/carsey/321>

districts, standards for practice and accountability, changes to how children are identified and served, and changes to the insurance model. To prompt such change, the DHHS has started to and will continue to survey child-serving areas within the department regarding their perceived alignment with a system of care. This will help DHHS prioritize program areas in order to assess necessary changes to policies and practices and to deliver training and technical assistance. A similar survey, which was cited earlier in this report, was issued to key provider agencies. DHHS has established a Care Management Entity to be the locus of responsibility for serving children and youth with very intense behavioral health needs. Additionally, DHHS has worked internally to expand this programming to include children and youth in open DCYF cases; both Child Protection and Juvenile Justice are involved. Historically, the access to residential treatment for children and youth who require that level of care has been very limited. Work internally at the department has begun to broaden access to this service. Targeted use of this service for children and youth not involved with DCYF can assist with more timely discharge from acute psychiatric hospitals, continued short term stabilization and treatment of the child's condition, and less need for rapid readmission to acute psychiatric hospitals after hospital discharge.

**Managed care and provider contracts.** As managed care contracts are amended and re-procured, there is an opportunity to assess documentation and billing requirements and practices that may be well aligned with a system of care approach. A more flexible array of services must be provided, and changes must be made to the Medicaid state plan. In the past year, the language within several different provider contracts have been changed in order to increase alignment with a system of care.

See Tables 3 and 4 for detailed descriptions of planned changes in policy and practice from the perspective of DHHS and DOE, respectively.

Table 3: DHHS Plan to Change Statutes, Rules, Policies, Practice, and Contracts

	<b>Plan to change</b>	<b>Target date</b>	<b>Comments</b>
<b>State Statutes and Rules</b>	None at this time.		
<b>Department Policies and Practices</b>	Identify each MH child serving area of DHHS (DCYF, BDS, BDAS, Public Health, NH Hospital) and send survey to self-assess where they are in the implementation/alignment of the 11 characteristics of a system of care, analyze the results and prioritize areas for improved alignment.	Survey completion by 1/30/18  Analysis and prioritization by 4/1/18  Training and technical assistance – Develop targeted training and TA materials by 12/1/18, begin training program areas 1/1/19	Work with each child serving program area on improved alignment with system of care; develop targeted training and TA for each program area relative to their practice, develop TA materials.  Prioritize program areas and deliver training and technical assistance.
	Identify key provider agencies to send survey. CMHC, FQHC’s, BDAS providers, CME and sub providers, DCYF identified providers, MCO’s, Hampstead Hospital.  Analyze the results and prioritize areas for improved alignment	Survey completion by 10/1/17  Analysis and prioritization by 1/1/18  Training and technical assistance – Develop targeted training and TA materials by 12/1/18, begin training program areas 1/1/19	Work with providers on improved alignment with SOC; develop targeted training and TA relative to their practice, develop TA materials.  Prioritize providers and deliver training and technical assistance to align practices.
	Work with NH Hospital for program improvements and alignment with system of care characteristics. Include in plan.	11/2017 plan due, implementation dates to follow	HB 400 work, consider the establishment of a new treatment location for NH Hospital APC. Recommendations submitted to legislature on 11/1/17.
	Early childhood SED Crosswalk for Service eligibility. Work with CMHC children’s directors, infant mental health group, and others.	Draft by January 2019	Rules and contract work to follow once complete.
	Youth Substance Use Treatment. enhancement-State Youth Treatment Plan and Implementation	September 2021	DHHS has been awarded an implementation grant to start enhancing the Substance Use Treatment system with effective practices to engage and keep

			engaged, youth and young adults needing treatment services.
	Develop a 10-year behavioral health plan.	July 1 2018	Use the CBHC plan as the foundation for the children, youth and young adult section of the plan. Plan to inform the need for any further changes to statutes, contracts, rules and practices.
<b>Rules</b>	He-M 400 series for CMCH's in process, adding language to address children, and system of care where able to an applicable.	Ongoing as rules expire	Continually assess barriers to implementation for needed statutory changes.
	DCYF certification rules	Ongoing as rules expire	Continually assess rules for needed changes, work with providers regarding the rules and how it impacts alignment. If a particular rule creates a barrier, seek an amendment.
<b>Managed Care and Provider Contracts</b>	MCO contracts now has beginning system of care language	Contract in process	If a particular rule creates a barrier, seek an amendment. Look to establish SOC values/principles in current rules. Ensure consistency in standards for BH service delivery.
	CMHC contract now has beginning system of care language	Complete	Connect to provider survey results, assess and work with providers on alignment. Adjust requirements in contract as needed.
	Establish a Care Management Entity (CME), by contract	Complete	CME contract approved on 6/21/17. Expand FAST Forward programming.
	Explore ability to amend current Mobile Crisis Contracts to include a child/youth approach to mobile crisis and increase capacity.	June 2018	Work with current Mobile Crisis providers to establish approach, work with providers on implementation plan and adjust requirements as needed.
	Youth SUD inpatient and outpatient treatment	In process	RFP being developed for treatment providers to provide both inpatient and outpatient substance use treatment for children, youth and young adults at the Sununu Youth Services Center.

Table 4: DOE Plan to Change Statutes, Rules, Policies, Practice, and Contracts			
	Plan to change	Target date	Comments
<b>State Statutes and Rules</b>	DOE has written the MTSS-B into the federal ESSA consolidated plan.		This will allow schools to have access to additional federal funds under Title IV to address mental and behavioral health issues.
<b>Department Policies and Practices</b>	Identify all responsibilities, tasks and priority areas within the DOE that align to the 11 characteristics of a system of care and self-assess where systemic alignment can be made to improve services.	Feb 2018	Bureaus with work in this area include, but are not limited to: Student Wellness, Title I, II, IV-B, Special Education, and Vocational Rehabilitation.
	Develop and implement a survey to public schools and DOE approved private providers to determine the extent/implementation/alignment of the 11 characteristics of a system of care. Analyze the results and prioritize areas for improved alignment.	June 2018	
<b>Rules</b>	None at this time.		
<b>Data Support</b>	DOE will work with the Department of Information Technology to add filter/query mechanisms into its Online Grants Management System so that DOE can easily collect and report data on the funds used for behavior health.	March 2018	
<b>Student Wellness</b>	DOE will work to elevate the Office of Student Wellness to a Bureau of Student Wellness.		This will allow for further alignment to system of care principles by have all mental and behavioral departments under one bureau.

#### D. Maximizing Federal and Private Insurance Funding

The DHHS and DOE have reviewed relevant federal funding sources and identified plans to maximize funding. For instance, DHHS has initiated rule changes to expand the use of Medicaid to Schools, with the intention of assisting schools to receive federal funding to help pay for behavioral health treatment in schools. Additional federal funding sources that are being targeted include, but are not limited to: mental health block grants, substance abuse disorder block grants, and the Medicaid state plan.

Access to behavioral health services through private insurance has expanded in recent years. More people have coverage, and most types of private insurance (individual market plans and employer-based coverage) now cover behavioral health services. Parity requirements dictate that any coverage for behavioral health services must be “on par” with coverage for medical-surgical services, in terms of both quantitative and non-quantitative treatment limits (e.g., copays, deductibles, visit limits, prior authorization requirements). However, there are some types of care, such as intense care management and crises teams, that are currently covered under public health care programs (such as Medicaid) but are not typically covered by private insurance.

There are two avenues by which the types of services covered by private health insurance in the state could be expanded. First, state coverage mandates could be expanded. This would require changes to state statute, and consequently political support. The second would be to convince private health insurers to expand coverage on their own—likely by highlighting the types of services that would reduce overall financial burden by reducing high-end costs (e.g. through cost-saving preventative measures). A good forum to address this work would be the meetings of the Advisory Committee on Insurance Coverage for Behavioral Health and Addiction Services, which New Hampshire Insurance Commissioner Roger Sevigny has established to foster dialogue among providers, legislators, insurance companies and advocates.

The New Hampshire Insurance Department (NHID) is also in the process of revising its network adequacy standards in a way that could increase access to behavioral health services, and foster a better understanding of the state’s capacity in this area of treatment. The NHID has used the state’s all-payer claims database to classify services based on the frequency of claims and the proximity to home with which these services are typically accessed. This revised model will be used to assess whether insurance companies’ networks are adequate – i.e., whether the plan’s network of service providers gives plan enrollees access to all services covered by the plan within a reasonable time and distance. Table 4 describes plans for maximizing federal and private insurance funding within DHHS, organized by funding source.

Table 4: DHHS Plan to Maximize Federal and Private Insurance Funding

Funding source	Approach or plan to maximize	Target date	Comments
<b>Mental Health Block Grant</b>	Use to help implement new approaches and evidence-based practices for children and youth. Identify and prioritize areas/practices for funding. Attempt to reach an equitable percentage of funding going to support children and youth areas versus adults.	Ongoing and as needed	Children’s Committee is working to develop a plan for future use of funds. Currently funding: <ul style="list-style-type: none"> <li>• MATCH and FEP, evidence based treatment approaches, are currently funded from this block grant.</li> <li>• NAMI NH receives funds from this block grant for Family Support Services.</li> </ul>
<b>Substance Use Disorder Block Grant</b>	Use to help implement new approaches and EBP’s for children and youth. Identify and prioritize areas/practices for funding. Attempt to reach an equitable % of funding going to support children and youth areas versus adults.	Ongoing and as needed	Currently funding: <ul style="list-style-type: none"> <li>• Student Assistance Programs (these are schools who received funding from the original PFS grant and we now use BG funds to help support those programs)</li> <li>• The Youth Council has an adolescent outpatient program</li> <li>• Funding for infrastructure development was used to fund the following programs: GNCA (adolescent trauma specific IOP) and Riverbend (adolescent IOP and adolescent MAT)</li> </ul>
<b>DCYF grants</b>	Use to help implement new approaches and EBP’s and align practices and standards for children and youth in DCYF care or meets Child Abuse Prevention and Treatment and Adoption (CAPTA) grant guidelines for prevention.	Ongoing and as needed	Supported FAST Forward for non-Medicaid services as prevention.
<b>Medicaid State Plan</b>	Develop the FAST Forward Medicaid benefit plan.	CMS approval date.	Decide which Medicaid authority to use, follow process for writing and approval. Work with providers on readiness and capacity, per House Bill 517.
<b>Medicaid to Schools</b>	Expand the use of Medicaid to schools, add services for BH treatment in schools	Initiate rule changes by 9/1/17	Decide which services to include. Decide how to document necessity for non IEP children, per Senate Bill 235.
<b>Medicaid-EPSDT Regulations</b>	Use EPSDT for sub-acute care for non DCYF involved children and youth. Work	Complete Ongoing provider	Expand to community based services/other services.

	with providers for implementation regarding use, and access.	assistance for access issues.	Work with Office of Medicaid business and policy staff for requirements and access. Work with DCYF to identify appropriate use for the Child Protection and Juvenile Justice Population. Educate providers on how to access.
<b>Braided funding across DHHS</b>	DCYF cases to be accepted into FAST Forward program. Daily rate and a CME contract are now in place.	November 15 2017	Details for implementation being worked out by workgroup, CME and NAMI to hire staff.  Look for other opportunities for braided funding/resources across DHHS (public health, ESS)
<b>Private Insurance</b>	DHHS/DOE to ask to present any services/approaches to the insurance departments' workgroup with medical directors, emphasizing return on investment and positive client health outcomes information.	Ongoing as needed	Prioritize FAST Forward and NH Wraparound once Medicaid Benefit is approved by CMS. Identify and prioritize other services and approaches to present.
<b>DSRIP 1115 Waiver</b>	Work with IDN's on child/youth approaches for applicable projects and child/youth approaches to integration of PC and BH	Ongoing as needed	BCBH involved in DHHS 1115 policy group and reviewing IDN project plans.
<b>Competitive Grants</b>	Apply for federal competitive grant opportunities to advance the expansion of approach, programming and services	Ongoing	

#### E. Summary of the Interagency Agreement

An Interagency Agreement (IAA) was signed by the New Hampshire Commissioners of Education and Health and Human Services on November 22, 2017. This document aims to enhance the ways in which the two agencies work together to realize efficiencies and improvements in children's behavioral health services. The IAA stipulates that each department will work to establish a system of care, and will work together to coordinate children's behavioral health services. This includes collaboration on the development of data systems related to RSA 135 F:7, jointly developing a plan for addressing gaps in service, and alignment of department training with a system of care approach. See Appendix H for the full IAA.

#### IV. Discussion

Considerable efforts have been made to implement a system of care in New Hampshire. Here we discuss priority areas that should receive additional attention as the work continues.

**Medicaid to Schools.** Work has begun on updating the Medicaid to School rules to align with the statute. This work will enable schools to access Medicaid reimbursement for services provided to children with both an IEP as well as those without an IEP. Prior to this legislation, only children with an IEP were able to receive services that could be reimbursed by Medicaid. Now schools will be able to access Medicaid dollars for Medicaid eligible children for Medicaid reimbursable services being provided by the school or a school vendor for that child. Additionally, services will be added to the rule that will help to expand and promote work being done at schools that align with a system of care and the provision of behavioral health services in the school setting.

**Medicaid benefit for children's mental health.** Development of a specific Medicaid state plan amendment and benefit to help sustain and expand system of care programming, FAST Forward has begun. This benefit will assist in expanding this program by bringing in critical components of the program into the Medicaid state plan and enabling the DHHS to draw federal participation for these services.

**Feedback on state ESSA plan.** The DOE recently conducted a regional listening tour and public survey regarding the submission in order to solicit the public's help in developing the key ideas that will ultimately become the core of our New Hampshire's consolidated ESSA plan. Overall, the DOE found strong support in New Hampshire for schools to support the behavioral health of its children. For instance, the survey found that 65.3 percent of respondents believe that the DOE should provide assistance in locating mental health services and providers to support students (and their families) who have experience trauma; the same survey found that 60.6 percent want schools to provide educators training on how to identify students' social and emotional needs and develop school-based programs, practices and/or interventions to specifically address those needs. These items elicited some of the most favorable responses of the survey and emphasize the support for the integration of behavioral health supports into schools.

**DHHS and DOE partnerships.** DHHS has partnered the DOE in the implementation activities associated with DOE's system of care grant. Assistance from DHHS to system of care involved schools include:

- Regular attendance at the Tier III implementation meeting to support and provide technical assistance to project managers.
- Provided feedback on documentation, policy, and practice for program.
- Share pitfalls, barriers and helpful hints to work through barriers.
- Direct coordinators to coaching and provide coaching feedback when needed

- Review certification process with wrap coordinators.
- Create and implement an Eligibility Coordinator training to assist with referral and eligibility process.
- Consult with Program Managers and Eligibility Coordinators around program specific questions.

**Data Limitations.** A limitation of this report, specifically, and in measuring progress around the implementation of a system of care more generally, relates to the availability of data. First, data systems are unable to accurately capture children behavioral health expenditures in the state, particularly in public schools. However, the DOE has identified a rather straightforward means of capturing Title expenditures directed at behavioral health in schools, and intends to do so for FY2018. Additionally, the DOE does not systematically capture local spending on children’s behavioral health, and this spending is likely to be quite substantial across the state. A case study examination into five New Hampshire school districts revealed some of the ways in which schools are involved in the provisioning of behavioral health services, and makes recommendations as to how more precise data collections may be conducted in this area. Additionally, barriers can be removed that will allow for DOE and DHHS data to be linked, with implications for measuring the effects of services across groups that are involved in both DOE and DHHS systems.

**Workforce Challenges.** A review of the literature identified a number of challenges to adequate staffing of the behavioral health workforce in New Hampshire, which suggests that New Hampshire is experiencing similar challenges to other states in recruiting and retaining a qualified behavioral health workforce. Nationally, the workforce is aging, turnover is high, recruitment efforts are lacking, and training is out of sync with the realities of service provision. Staffing shortages in New Hampshire are especially acute for certain professions (e.g., child and adolescent psychiatrists), as well as in certain areas, such as more rural locales. A lack of sufficient behavioral workforce data is problematic everywhere, including in New Hampshire, and this hinders workforce planning and capacity-building efforts.

One initiative aimed at addressing workforce challenges is the New Hampshire Children’s Behavioral Health Workforce Development Network (the Network). Formed in 2009, the Network includes over 40 providers, trainers, family and youth-led organizations, state leaders, and university program directors with a mission to improve the competencies of the workforce that services children and youth with emotional and behavioral challenges and their families. The Network has created a set of core competencies, conducted assessments of 11 college and university programs in the context of system of care values and principles, has brought evidence-based programs to the state (such as Modularized Approach to Therapy for Children), created 18 free online modules focus on system of care values and approaches, and school-based training for PBIS. The Network is a key resource for training and collaboration focused on children’s behavioral health.

## Appendix A

### New Hampshire Department of Health & Human Services Expenditures, Children's Behavioral Health Services

Name	Funding Source	Level of Support	Description	Total Expenditures SFY 2015	Total Expenditures SFY 2016	Change in Total Expenditures SFY 2016 - SFY 2015
Child Protection	General Funds	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intensive in home supports, therapeutic foster care, and shelter care services.	\$1,355,894	\$1,791,597	\$435,703
	Title IV-E funds	Tertiary	Intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	\$1,878,171	\$1,700,079	-\$178,093
	TANF	Tertiary	In home therapy services, intensive in home supports and treatments.	\$75,898	\$71,687	-\$4,211
	Title IV-A Emergency Assistance	Tertiary	Intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	\$792,357	\$1,189,532	\$397,175
	Medicaid	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intensive in home supports, therapeutic foster care, and shelter care services.	\$8,669,277	\$11,452,168	\$2,782,891
Juvenile Justice	General Funds	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intensive in home supports, therapeutic foster care, and shelter care services.	\$1,780,172	\$2,834,804	\$1,054,632
	Title IV-E funds	Tertiary	Intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	\$2,345,316	\$1,269,358	-\$1,075,958
	TANF	Tertiary	In home therapy services, Intensive in home supports and treatments.	\$110,304	\$110,306	\$2
	Title IV-A Emergency Assistance	Tertiary	intensive group home, intermediate group home, therapeutic foster care, residential treatment and shelter care services.	\$4,368,873	\$4,369,158	\$285
	Medicaid	Tertiary	Diagnostic evaluations, in home therapy services, intensive group home, intermediate group home, residential treatment, Intensive in home supports, therapeutic foster care, and shelter care services.	\$11,899,853	\$11,857,738	-\$42,115
Sununu Youth Services Center	General Funds	Tertiary	Screening and assessment for Behavioral Health and Substance use disorders, individual family and group counseling, restorative justice circles, psychiatry and medication management.	\$1,345,994	\$1,356,937	\$10,943
Juvenile Diversion	Juvenile Justice block grant	Secondary	Juvenile diversion services for first time offending youth	\$183,806	\$340,000	\$156,194
Child Care Scholarship	Federal Funds	Primary	Enhanced rate for children with emotional disability	\$3,545	\$21,900	\$18,355
		Secondary	Behavioral support consultation services for early learning centers for children with emotional disabilities.	\$130,000	\$140,426	\$10,426
PTAN Family Resource Centers	Federal and state dollars	Primary and Secondary	Prevention, treatment activities such as Home Visiting and other family preservation programming.	\$1,751,128	\$1,439,419	-\$311,709
<b>TOTAL</b>				<b>\$36,690,587</b>	<b>\$39,945,108</b>	<b>\$3,254,521</b>

## Appendix B

### New Hampshire Department of Health & Human Services Expenditures, Children's Behavioral Health Services

Name	Funding Source	Level of Support	Description	Total Expenditures SFY 2015	Total Expenditures SFY 2016	Change in Total Expenditures SFY 2016 - SFY2015
General Medicaid	Federal	Primary, Secondary, and Tertiary	Services to include: All services provided by CMHC's, and private Medicaid providers, includes all inpatient, outpatient and pharmacy claims related to Behavioral Health Services.	\$23,613,857	\$33,887,441	\$10,273,584
	General	Primary, Secondary, and Tertiary		\$23,613,857	\$33,887,441	\$10,273,584
NH Hospital	General Funds	Tertiary	Acute psychiatric hospital care for children.	\$3,800,000	\$3,800,000	\$0
	Medicaid	Tertiary		\$5,344,743	\$5,487,971	\$143,228
FAST Forward and other programming	Federal and State dollars combined		FAST Forard: Programming to serve children and youth with Severe Emotional Disturbances and who are at risk for out of home placement.	\$4,000,000	\$3,500,000	-\$500,000
Student Assistance Program	Federal Grant dollars	Secondary and Tertiary	Prevention education, school-wide awareness activities, brief individual counseling, group sessions, parent education, and referral to community services	\$511,692	\$1,713,362	\$1,201,670
Family Resource Centers	Federal and State dollars combined	Primary, Secondary, and Tertiary	Alcohol and drug prevention contracts.	\$9,469	\$9,469	\$0
Contracted services	Federal and State dollars combined	Primary, Secondary, and Tertiary	Substance misuse treatment services, screening, assessment, outpatient treatment and residential treatment.	\$203,431	\$74,547	-\$128,884
RENEW Transition Intervention	Balancing Incentive Program Grant	Tertiary	Training and coaching support and infrastructure development for Community Mental Health Center staff to provide a research-based intervention.	\$328,619	\$323,735	-\$4,884
<b>TOTAL</b>				<b>\$61,425,668</b>	<b>\$82,683,966</b>	<b>\$21,258,298</b>

## Appendix C

### Sub-expenditures, General Medicaid 2016, Children's Behavioral Health Services in New Hampshire

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Service Category	Expenditures
Inpatient	\$2,968,313
Outpatient Hospital	\$1,663,094
CMHC	\$24,572,537
Medicaid to Schools	\$4,400,037
Other (physician services, clinic, etc.)	\$16,075,985
Pharmacy	\$18,094,918
<b>TOTAL</b>	<b>\$67,774,884</b>

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## Appendix D

### New Hampshire Department of Health & Human Services Expenditures, Children's Behavioral Health Services

Name	Funding Source	Level of Support	Description	Total Expenditures SFY 2015	Total Expenditures SFY 2016	Change in Total Expenditures SFY 2016-2015
BDS and Special Medical Services	Federal and general funds	Primary and Tertiary	Psychiatry and Psychology consultation services for 0-21 being served by Developmental Services and Special Medical Services programming	\$143,119	\$143,119	\$0
Early Supports and Services/ Developmental Services	Federal funds	Primary	Early assessment, diagnosis and treatment	\$340,187	\$99,196	-\$240,991
<b>TOTAL</b>				<b>\$483,306</b>	<b>\$242,315</b>	<b>-\$240,991</b>

## Appendix E

### New Hampshire School-Based Expenditures, Titles I, II, and IVb Programming, Children's Behavioral Health Services

Category	Description	Level of Support	Title I Expenditures SFY 2016	Title II Expenditures SFY 2016	Title IVb Expenditures SFY 2016	Total Expenditures SFY 2016	Title I Expenditures SFY 2017*	Title II Expenditures SFY 2017*	Title IVb Expenditures SFY 2017	Total Expenditures SFY 2017	Change in Total Expenditures SFY 2017 - SFY 2016
PBIS	Positive Behavior Interventions and Supports is a tiered process whereby schools identify the needs of students at a Universal screening level. Students are provided with positive interventions to support a strong culture of behavior within a school. PBIS then supports students as needed at a secondary and tertiary level, increasing interventions as appropriate in order to achieve positive behaviors in students.	Primary, Secondary, and Tertiary	\$67,803	\$10,395	\$0	\$78,198	\$69,159.00	\$9,148	\$0	\$78,307	\$109
Responsive Classroom	An approach to education that emphasizes social, emotional, as well as academic growth in a strong and positive school community	Primary	\$6,914	\$234,217	\$0	\$241,131	\$7,052.00	\$206,111	\$0	\$213,163	-\$27,968
Service Providers (social workers, counselors, etc.)	Schools often utilize paraprofessionals, social workers, and counselors in order to support student needs. These individuals may work with small groups of students, individuals, in an inclusive setting, or be used for pull out supports. These services often result in strong relationships for students with behavioral health needs.	Primary	\$3,506	\$805,390	\$0	\$808,896	\$3,576.00	\$708,743	\$0	\$712,319	-\$96,577
Other Programs	N/A	N/A	\$0	\$65,345	\$0	\$65,345	\$0	\$57,504	\$0	\$57,504	-\$7,841
Speakers and Professional Development	Teachers constantly strive to learn from experts in order to better serve their students. Professional Development opportunities and guest speakers provide a means for teachers to learn about their students with Behavioral Health needs or about how to implement a program to support these students. Such opportunities often lead to school-wide interventions or individual changes in teacher practice in the classroom.	Tertiary	\$0	\$81,753	\$0	\$81,753	\$0	\$71,943	\$0	\$71,943	-\$9,810
Instructional Rounds	Instructional Rounds include the training of teachers and leaders to objectively observe practices taking place in the classroom. After practices are observed, teachers are able to obtain feedback about effectiveness and work with peers/mentors/administrators in order to change practice to best meet the needs of students or are recruited to share outstanding practices with colleagues.	Tertiary	\$0	\$22,966	\$0	\$106,619	\$0	\$20,210	\$0	\$20,210	-\$86,409
21st Century After School Program	Provides students with extended day and extended year services. The programs promote after school learning and summer school activities, both focused on ensuring students have a safe, healthy environment to receive remediation and enrichment for their academics. The programs also support healthy relationships with peers and adults, and promote family and community engagement through information nights and celebrations.	Secondary	\$0	\$0	\$3,600,000	\$3,600,000	\$0	\$0	\$4,765,586	\$4,765,586	\$1,165,586
Other unidentified	N/A	N/A	\$0	\$26,500	\$0	\$0	\$0	\$23,320	\$0	\$23,320	\$23,320
<b>TOTAL</b>			<b>\$78,223</b>	<b>\$1,246,565</b>	<b>\$3,600,000</b>	<b>\$4,924,788</b>	<b>\$79,787</b>	<b>\$1,096,979</b>	<b>\$4,765,586</b>	<b>\$5,942,352</b>	<b>\$1,017,563</b>

\* Due to capacity challenges at the Department of Education in collecting FY 17 data for Title I and II data, the following methodology has been used: In FY16, the Department received a total of \$38,483,985 for Title I Program expenses. Estimated expenditures for children's behavioral health reported last year was \$78,223. This is approximately .02% of the amount received. Therefore, due to the ability for school districts to use their funds over multiple years, we expect the FY17 expenses to be approximately \$79,787. The same methodology is in effect for Title II dollars. In FY16 we received \$10,188,879 and 12% of those funds were reported as being used for children's behavior health. In FY17, we received less funds in the amount of \$10,001,027. Therefore we expect the FY17 expended to be approximately \$1,096,977.

# **Children's Behavioral Health Expenditures in New Hampshire Schools: A Five District Case Study**

DRAFT

Prepared for The Endowment for Health

December 1, 2017

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Douglas Gagnon joined the Carsey School of Public Policy as a Research Associate in 2015 after serving as a Research Assistant since 2012. Doug's research has focused primarily on education policy as it relates to the equality of opportunity, teacher quality and school staffing, and trends in student discipline. He recently joined the Evaluation Program at Carsey in order to manage the external evaluation of the UNH Teacher Residency for Rural Education (TRRE), a U.S. Department of Education-funded program that prepares elementary and secondary mathematics and science teachers to teach in rural, high-need schools in northern New Hampshire. Prior to earning his Ph.D. in Education Policy from the University of New Hampshire, Doug spent nearly a decade as a high school physics teacher and a curriculum and assessment specialist.

Beth Mattingly is director of research on vulnerable families at the Carsey School of Public Policy. She manages all of Carsey's policy relevant work relating to family well-being. Topics covered by the vulnerable families research team range from refundable tax credits, Supplemental Nutrition Assistance Program (SNAP) and other federal programs, as well as policies that help families balance the domains of work and family like access to affordable child care and paid sick leave. Her interests center on women, children, and family well-being. Her work at Carsey examines child poverty and how different family policies affect rural, suburban, and urban families and how growing up in poverty influences life outcomes. Beth's research also looks at obstacles to stabilities in family life and how state and federal policies may better support children and families.

Special thanks to members of the New Hampshire Children's Behavioral Health System of Care Steering Committee for providing feedback on this report. Any errors within are those of the authors.

In June 2016, Senate Bill 534-FN was signed into law, requiring the State of New Hampshire to implement a system of care for children’s behavioral health. This legislation aims to increase service effectiveness for children with behavioral health challenges, reduce the cost of services by leveraging outside funding and reducing duplication across agencies, and to coordinate the care for children involved in multiple systems across the state. On December 1<sup>st</sup> of each year, the commissioners of the Department of Health & Human Services (DHHS) and the Department of Education (DOE) must jointly issue a report that addresses a host of factors related to the implementation of a system of care, including the total cost of children’s behavioral services in the state. Generating accurate estimates of such expenditures is an especially challenging proposition when it comes to education, primarily for two reasons. First, educational spending remains largely a local responsibility, and the state does not currently capture such financial data at a level of granularity that would allow for such estimates. Second, there is likely to be considerable variability across schools as to what constitutes a behavioral health service, and the ease at which districts can track such spending. This study begins to fill this gap in knowledge by gathering financial data from a sample of New Hampshire school districts and conducting focus groups with key administrators to uncover practitioner understanding.

### **Key Findings**

Larger school districts, and districts with a shorter history of implementing behavioral health initiatives, will likely have a greater challenge gathering and categorizing data on behavioral health expenditures.

Due to the integrated nature of education and a lack of a common understanding as to what constitutes a behavioral health service, districts exhibited divergent accounts of personnel expenditures for behavioral health despite rather similar levels of staffing and service provided across the districts.

Administrators prefer to frame differences of intensity in behavioral health services as tiers of intervention, as opposed to levels of treatment.

Many administrators were reluctant to describe certain expenditures as serving a distinct group of students, as many students who do not directly receive services still accrue benefits indirectly.

## Study Design

The sample in this study consists of five school districts in New Hampshire. An effort was made to have representativeness in relationship to four factors: poverty, area of the state (county), size (enrollment), and prior affiliation with the DOE's Office of Student Wellness. Table 1 shows that participating districts do exhibit considerable variation along these domains.

Table 1. Sample Composition: District Poverty, Enrollment, County Representation, and Prior Affiliation with OSW.

Factor	Sample Composition
Poverty	Two districts have rates of student poverty higher than the state average, and three districts have rates lower than average.
Enrollment	One district enrolls less than 1,000 students, two districts enroll between 1,000 and 3,000 students, and two districts enroll more than 3,000 students.
County	Districts are located in Hillsborough, Rockingham, Strafford, Merrimack, and Coos Counties.
OSW Affiliation	Two districts had a prior affiliation with OSW, and three did not.

There were two forms of data collection in this study: district financial data gathering, and a focus group. Each participating district was first sent a graphical organizer well in advance of meeting as a focus group. The graphical organizer outlined the expenditure data to be collected, dividing behavioral health expenditures into four categories: personnel, professional development, programming for socioemotional learning, and other preventative and intervention services for behavioral health. The graphical organizer also prompted districts to describe expenditures along three different domains: funding source, treatment level, and characteristics of service recipients.

Once financial data gathering was completed, semi-structured focus groups were conducted. Participant districts were instructed to invite all individuals in the district whose input was required for completing the data collection. We used these focus groups to gather information in several key areas. First, we inquired about the process by which a district gathered data, including who needs to be involved, where the data reside, and how difficult it was to complete such data gathering. Next, we honed in on terminology, gathering feedback as to the appropriateness and completeness of our proposed categories and desired descriptions of behavioral health expenditures. Finally, we solicited district advice regarding future efforts to collect data more systematically across the state. The results here are presented in the language of the participants to the extent possible in order to most accurately represent their understanding.

## Gathering Data

Participating districts used different processes to gather data on behavioral health expenditures. In the smallest participating district, the Director of Student Services completed all required data fields without requiring input from other administrators in the district. Because

this Director is intimately involved with all aspects of behavioral health services in the district, including budgeting and planning teacher professional development activities, she felt confident that school-level administrators need not be consulted to gather accurate data. Other districts did complete data gathering with the help of some school-level administrators, and were equivocal as to its completeness. Some suggested that their district's efforts around behavioral health services in recent years had increased awareness about this work at the district level, and that gathering such data would have been a far more complex task if attempted only a few years ago. It seems likely that larger districts, districts without a dedicated a manager/director of student behavioral health services, and/or districts that have yet to strongly consider the role of behavioral health services in their schools would have more difficulty in collecting these data—especially in regards to non-personnel expenditures.

### **Categorizing Expenditures**

Personnel costs constituted by far the greatest share of behavioral health expenditures. However, there was tremendous variation across the sample districts as to which positions were deemed to have a behavioral health component. For instance, one district estimated yearly behavioral health expenditures of approximately \$4.5 million—or roughly one tenth of their total operating budget—and all but \$52,000 were associated with paying the salary of district staff who primarily work to provide behavioral supports to students, and contracts with outside organizations that deliver behavioral health services within the district.

However, there was considerable range as to the level of personnel spending across the five participating districts. One district had previously registered with the School Health Assessment and Performance Evaluation (SHAPE) system, which prompted the district to adopt a wide notion of the district personnel whose salary should be considered a behavioral health expense, including the full salary of all district- and school-level administrators, occupational therapists, and speech/language therapists, in addition to those positions with a more explicit connection to behavioral health (e.g. school social worker). In contrast, another district construed behavioral health in a far narrower sense, only considering school psychologists, behavioral specialists, and student support staff as a related expense. Yet another district estimated the portion of educator positions that were dedicated to behavioral health services specifically (e.g. school-based administrators at 10%, behavioral specialists at 50%, etc.), with only this identified portion of each position's corresponding salary being considered a behavioral expense.

These differences were not due to disparate positional responsibilities across districts but rather due to a lack of a common understanding as to what constitutes a behavioral health service, as well as the difficulty in parsing these services from other responsibilities of schools. Many administrators noted that behavioral health support is embedded into every staff member's job to some extent, and that best practice suggests an integrated approach to promoting holistic development of children. Ultimately, administrators found it difficult to disentangle responsibilities related to children's behavioral health, specifically, as opposed to academic success, as each form of development supports the other. Therefore, we present limited financial data here as to do so would be rather arbitrary, though the gathering of personnel costs is a straightforward task once behavioral health personnel have been identified for inclusion.

Data gathered by districts along other the outlined categories—professional development, programming for socioemotional learning, and other preventative and intervention services—was highly variable. For instance, some districts considered the expense of certain students placed out-of-district as behavioral health expenditure, and noted that this was a significant financial burden on the district. Other districts did not discuss such costs whatsoever, though they likely did have to send some students outside of the district for student behavioral health needs to be met. Collection of data on professional development expenses also differed considerably. One participating administrator, who was closely connected with delivering professional development throughout the district, was confident in the classifications made; another district did not have such a centralized repository for understanding the content of all professional development activities, instead looking to the title of professional development expenses to determine if it was a behavioral health focused expense. During focus groups, districts would often identify additional programs and curricular packages which had some focus on behavioral health and ultimately could have been included in their original data collection. Overall, given the minimal guidance as to what is considered a behavioral health expense, financial data gathered during this investigation is too imprecise to yield informative estimates for individual districts, and for this reason we do not present such expenditure data here.

### **Describing Expenditures**

Districts easily identified the funding source of behavioral health expenditures, with general funds (i.e. state and local dollars) representing the bulk of funding. Additionally, funds came from state grants, federal sources (e.g. IDEA funding), and private sources. Districts had difficulty characterizing the types of students that are served via certain expenditures, noting that, at least for less prescriptive expenses, there is a responsibility to help all students in their care. Moreover, the nature of most behavioral health services is such that there is at least an ancillary benefit to all students under their care. We found that all participating districts were reluctant to describe expenditures as being at the primary, secondary, or tertiary level of treatment. Many administrators noted that “treatment” implies a level of service not provided by schools, and that systems of tiered intervention are a framing more consistent with educational contexts. With this framing, administrators described behavioral health expenditures that provide for services along the full range of intervention, including universal strategies or (tier 1), more targeted interventions for groups of students who require greater supports (tier 2), and intensive individual services (tier 3). Table 2 provides examples of behavioral health services in participating districts within each tier of intervention.

Table 2. Examples of Behavioral Health Services in Districts, Tiers 1, 2, and 3

Tier	Examples
1	<p><b>Substance misuse prevention.</b> Grade-wide initiatives providing students with strategies and techniques related to substance abuse prevention and healthy development.</p> <p><b>Classroom counseling curricula.</b> Middle school counselors creating and delivering lessons to all students in an effort to provide students with the necessary behavioral skills to act and respond to challenges in appropriate ways.</p>
2	<p><b>Small group special education services.</b> Special educators providing additional integrated behavioral supports in traditional classroom settings for students with a disability.</p> <p><b>Nonviolent crisis intervention.</b> School staff receive training on early intervention, non-physical techniques, and safety strategies for working with students identified as having disruptive, unsafe and escalating behavior. Staff then work with these students in small group settings to provide students with disengagement skills that help prevent unsafe and physical behavior.</p>
3	<p><b>Contracted Behavioral Service Providers.</b> Intense one-to-one counseling services delivered to at-risk students and consulting services provided to school staff in developing individualized student behavioral plans.</p> <p><b>Services for students who are homeless.</b> Extra services (e.g. tutoring, food assistance, etc.) provided to these students to generate a broad system of support for a population whose behavioral health is particularly at risk.</p>

## Implications

The findings of this investigation offer guidance as to how the state should proceed with more systematic data collection of behavioral health expenditures in schools. A more prescriptive data collection protocol, developed with input from educators, would allow for districts to gather data in a consistent manner. Findings from the focus groups lead us to make several recommendations for promoting structured and reliable data collections in the future.

### **Box 1: Recommendations for Future Data Collection Efforts**

The positions that constitute behavioral health personnel should be clarified. In cases where only a portion of a position is directed towards behavioral health, related literature and educator input should inform a proportional estimate (e.g., percent of time spend on behavioral health services for a high school guidance counselor).

Out-of-district placements that arise as a result of behavioral health factors could represent a significant cost to districts, and should be captured to the extent possible.

Categories of expenditures should be grouped into four mutually exclusive areas: personnel, outside contracted services, out-of-district placements, and other expenses (professional development, supplies, programmatic and curricular expenses, etc.).

A considerable but non-exhaustive list of examples of qualifying professional development and programmatic expenses should be generated and provided within the data collection tool.

A “tiers of intervention” framework should be employed to examine how expenditures vary by intensity in districts. Districts are generally very familiar with tiered intervention frameworks through such initiatives and Responsive Classroom, Positive Behavior Interventions and Supports (PBIS), and Response to Intervention (RTI), all of which group services into universal, targeted, and individual tiers.

If there is a desire to better understand the characteristics of students served by particular expenditures, categorical groupings should be minimal and important. Moreover, there should be an understanding that even in cases where funding is dedicated to a certain group of students, there are often positive spillover to students not directly served.

A draft of a revised data collection tool (e.g. survey) should be reviewed by school behavioral health specialists, perhaps by conducting additional regional focus groups at existing professional education conferences within the state.

# **Children's Behavioral Health Workforce in New Hampshire: A Literature Review**

DRAFT

Prepared for The Endowment for Health

December 1, 2017

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Beth Mattingly is director of research on vulnerable families at the Carsey School of Public Policy. She manages all of Carsey's policy relevant work relating to family well-being. Topics covered by the vulnerable families research team range from refundable tax credits, Supplemental Nutrition Assistance Program (SNAP) and other federal programs, as well as policies that help families balance the domains of work and family like access to affordable child care and paid sick leave. Her interests center on women, children, and family well-being. Her work at Carsey examines child poverty and how different family policies affect rural, suburban, and urban families and how growing up in poverty influences life outcomes. Beth's research also looks at obstacles to stabilities in family life and how state and federal policies may better support children and families.

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## Executive Summary

This literature review describes the behavioral health workforce landscape in New Hampshire K-12 schools and Community Mental Health Centers (CMHC), as well as workforce conditions in New Hampshire. Factors such as wait lists, caseload ratios, remuneration, staff turnover, uncompensated care, and licensing reciprocity are assessed to develop an in-depth description of behavioral health workforce conditions. Conditions in New Hampshire are compared to neighboring states and to national trends when possible, though a lack of uniform, reliable, and comprehensive behavioral health workforce data is problematic nationwide. Existing literature on the causes and effects of insufficient staffing, and strategies to address this issue, are discussed as well.

### Key Findings

There are severe shortages across a number of behavioral health professionals nationwide. This is especially true of child and adolescent psychiatrists, with 42 states having almost 6000 or more children per practitioner. Shortages are particularly acute in rural areas, with two counties in New Hampshire (Coos and Carroll) supporting no practicing child and adolescent psychiatrists.

Low pay is seen as a major barrier to sufficient staffing levels in the behavioral health workforce. For instance, one report found a licensed professional social worker, a position that typically requires a Master's degree and 2,000 hours of post-graduate experience, earned less than a manager of a fast food restaurant. Workforce pay in New Hampshire is generally lower than that of neighboring Massachusetts.

While pay is a concern across many professions, it varies considerably. For example, community health workers in centers in New Hampshire are estimated to earn a median annual income of just \$30,460 annually, while that of registered nurses falls at \$59,050.

Policy and legislative barriers have been tied to high turnover rates of behavioral health professionals, which in turn increase pressure on remaining staff members. Further, state licensure rules can prevent qualified providers from being able to work, and can in some cases impede billing for services.

Current data systems inadequately capture the full picture of the behavioral health workforce landscape, hindering workforce planning and capacity-building efforts.

### Provider scarcity is pervasive, particularly in rural areas

Nationally, the supply of behavioral health specialists is shrinking. New Hampshire is one of 42 states classified by the American Academy of Child & Adolescent Psychiatry as having a severe shortage of practicing child and adolescent psychiatrists. Consistent with national trends, New Hampshire is experiencing a particularly acute provider deficit in rural areas, with Coos and Carroll Counties both lacking any practicing child psychiatrists. A greater number of federally designated Mental Health Care Professional Shortage Areas exist in Coos county than any other county in the state.

## **Workforce conditions point to overworked and underpaid providers**

Conditions in New Hampshire reflect national trends in many ways. In New Hampshire and elsewhere, long wait lists to see an available provider are intensified by high youth-to-provider ratios and high turnover rates in the workforce. Low behavioral health provider salaries persist in New Hampshire and nationwide relative to professionals in comparable health care sectors and in business, though salaries tend to be higher in rural areas due to a lack of provider supply. Specific comparisons of available population-to-provider estimates of workforce adequacy, as well as provider salary estimate comparisons between New Hampshire, New England, and the nation, typically find New Hampshire faring worse than regional New England averages but better than the nation overall. A regional comparison of New Hampshire to neighboring states on these metrics largely shows New Hampshire falling behind Massachusetts, and generally close to Maine and Vermont. Uncompensated care is universally problematic. Licensing reciprocity varies by state and profession, with New Hampshire participating in some, but not all, catalogued efforts to facilitate ease of licensing transfer between states.

## **Multiple overlapping factors lead to insufficient staffing levels**

Nationally-focused publications highlight a growing demand for services and a small, shrinking supply of providers as factors associated with insufficient staffing levels. For several reasons, provider supply is inadequate to meet demand. First, the current workforce is aging, with many clinically trained professionals approaching retirement. Second, training programs do not adequately reflect ongoing changes to policy and practice, which prevents practitioners from effectively serving children and families. Third, fewer physicians are choosing to specialize in child and adolescent psychiatry, largely because of financial disincentives (e.g., low salaries and reimbursement rates) associated with this career choice. Fourth, the behavioral health workforce does not adequately reflect the racial and ethnic diversity of the population, which negatively impacts treatment outcomes for minority groups. Fifth, high turnover rates in the workforce disrupt therapeutic relationships and create added costs for employers. Sixth, a lack of comprehensive data on the size, scope, and characteristics of the workforce harms the effectiveness of planning efforts.

In New Hampshire, concerns about insufficient staffing highlight the lack of practicing child psychiatrists, particularly in rural areas. State policy and legislative barriers that limit staff autonomy and effectiveness, and feed into high turnover rates, have been identified as constraining factors that work against efforts to achieve sufficient staffing levels. The lack of high-quality, complete workforce data prevents a full assessment of staffing needs in the state's behavioral health workforce.

## **Strategies to address staff shortages focus on capacity-building**

Nationally, published strategies to address behavioral health staff shortages concentrate on building capacity and improving training, recruitment, and retention efforts. Capacity building includes expanding the depth of the current workforce – e.g., training certain providers to take on enhanced responsibilities – and the breadth of the provider network – e.g., utilizing trained families, peers, and volunteer mentors to expand the reach of services. Improvements to training

involve focusing on evidence-based teaching and the development of required core competencies across different sectors in the field. Recruitment and retention efforts include promoting long-term professional growth among local entry-level employees and enhancing financial benefits (e.g., tuition assistance for students and wages for practicing professionals).

Similar to national ideas, New Hampshire strategies for addressing staff shortages include enhanced training, capacity building, and financial incentives. Additional ideas involve streamlining the complex existing system of licensure and certification requirements, and enhancing data collection efforts to better understand workforce adequacy and inform planning efforts.

### **Looking to the future**

The nationwide lack of uniform, reliable behavioral health workforce data suggests that the compilation and analysis of such data would be a productive next step for government and other stakeholders in New Hampshire. Development, upkeep, and continued analysis of a behavioral health data repository, ideally including available comparative data from other states and/or regions, could be used to inform workforce planning and capacity building efforts.

DRAFT

## Introduction

This document presents the results of a literature review aimed at describing the behavioral health workforce landscape in New Hampshire schools and Community Mental Health Centers (CMHC), examining behavioral health workforce conditions in New Hampshire, and comparing New Hampshire's workforce conditions to nearby states and to national trends. The causes and effects of insufficient staffing, as well as strategies to address insufficient staffing, are covered as well. The results of this literature review may inform future government and other stakeholder workforce development and capacity-building efforts in New Hampshire.

The behavioral health workforce literature generally identifies a lack of existing data as being problematic at the local, state, and national levels. Uniform, reliable, comprehensive data related to the size, composition, and characteristics of the behavioral health workforce are not presently available.<sup>i</sup> Recently, the Behavioral Health Workforce Research Center created a minimum data set instrument for the behavioral health workforce in an effort to standardize data collection and inform workforce planning efforts.<sup>ii</sup> However, pending widespread adoption of this instrument, available data remains fragmented and incomplete. This literature review compiles available data from a variety of sources, including government and nonprofit publications, professional associations, survey results, labor statistics, and news media.

## Behavioral health workforce conditions: comparing New Hampshire to other states and national trends

Nationally, the behavioral health specialist workforce is aging, and replacement of retiring professionals will be difficult as there is a shortage of students specializing in behavioral health fields.<sup>iii</sup> The lack of child and adolescent psychiatrists and specialized professionals to treat substance abuse disorders among adolescents is particularly acute.<sup>iv</sup>

Provider shortages have a geographic component. Much of the current behavioral health workforce is located in urban and suburban areas; rural areas tend to have recruitment and retention difficulties.<sup>v</sup> The Substance Abuse and Mental Health Services Administration (SAMHSA) has found that rural counties and counties with low per capita income are most likely to experience unmet need.<sup>vi</sup> As of July 2017, over 1,000 geographic areas nationwide had been identified by the Health Resources and Services Administration as experiencing a shortage of mental health professionals. To address this shortage, 1,783 additional practitioners would be needed.<sup>vii</sup>

Given the shortage of trained specialists, professionals who lack specialty training are increasingly providing behavioral healthcare to children.<sup>viii</sup> More than 50 percent of patients are presently treated for behavioral health issues by their primary care providers (PCPs), most of whom have not received sufficient training in behavioral health.<sup>ix</sup> A 2004 issue brief on the capacity of the children's mental health workforce notes that most prescriptions for psychotropic medication for children are written by pediatricians and family physicians, not psychiatrists.<sup>x</sup>

Multiple indicators were assessed to develop an in-depth description of behavioral health workforce conditions in New Hampshire, other states, and nationally. This literature review sought information on factors such as wait lists, caseload ratios, remuneration, staff turnover,

uncompensated care, and licensing reciprocity. Due to data scarcity, direct comparisons between states on metrics like typical caseload ratios and wait lists were not always possible. Available state and national data are presented and discussed in relation to available New Hampshire data.

### *Wait lists and caseload ratios*

Wait lists and caseload ratios are overlapping factors related to workforce adequacy and ability to meet regional care needs. As mentioned above, national literature indicates that mental health providers are scarce nationwide, particularly in rural areas. This scarcity can lead to long wait lists and high youth-to-provider ratios. Population-to-provider ratios are a common indicator for workforce adequacy<sup>xi</sup>, while aggregate provider caseload data are rarely found in the literature. In healthcare, a provider's caseload is most simply defined as the mean number of patient visits each day.<sup>xii</sup> More complex estimates of target provider caseload, to inform organization planning efforts, approximate the total number of patients that a provider (e.g., a psychiatrist) can carry based on appointment timing and frequency while balancing additional work responsibilities.<sup>xiii</sup> Such estimates may inform judgments of provider adequacy within an organization. On a larger scale, estimates of population-to-provider are used to understand the number of providers relative to populations with certain needs or in certain geographic areas.<sup>xiv</sup>

The Bureau of Labor Statistics (BLS) produces annual research estimates of employment in behavioral health occupations in elementary and secondary schools and outpatient mental health and substance abuse centers (the broad employment sector that most closely reflects CMHC).<sup>1</sup> These data were combined with state elementary and secondary school enrollment and general population data to create students-per-provider and residents-per-provider estimates. Table 1 displays these estimates for New Hampshire and neighboring states Massachusetts, Maine, and Vermont.

In future comparisons made within this literature review, national and New England estimates are included in addition to New Hampshire and neighboring state estimates. For Table 1, it was not possible to create national and New England estimates with the data sources that were used for the individual states. For elementary and secondary schools, a compilation of national population data on actual student enrollment in all states is unavailable. For outpatient mental health and substance abuse centers, BLS research estimates are not available for every position (e.g., nurse practitioners, psychologists). National estimates would not be useful, given the inconsistency in position estimates available for different states. This inconsistency is evident in Table 1 as it shows different types of provider estimates available for positions in New Hampshire and neighboring states.

The BLS estimates are also only provided for major occupation groups, while minor occupation group estimates are not available. Given varied staffing structures, it is likely that different types

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<sup>1</sup> Data are compiled from sample surveys, and as such are subject to sampling and non-sampling error. Specifically, data are collected from the category of "outpatient substance abuse and mental health centers" which is the closest available category to Community Mental Health Center, but also includes outpatient detox, drug treatment, and alcoholism treatment centers. Data and complete information regarding the reliability of estimates is available at the OES Research Estimates by State and Industry website, [https://www.bls.gov/oes/current/oes\\_research\\_estimates.htm](https://www.bls.gov/oes/current/oes_research_estimates.htm).

of minor occupation group positions, with varied responsibilities, are included in the major occupational group categories in different states. The occupation groups tracked by the BLS do not overlap exactly with the direct services cohorts found at New Hampshire CMHC by Antal (2016), which include: Psychologist (Licensed), MD Psychiatrist, Family Support and Community Based (Masters/Licensed), Functional Family Support (FFS)/Case Management (with BA), Clinic Based (with Masters, in Not Licensed and Licensed categories), and staff with waivers (less than BA).<sup>xv</sup> It is possible to seek overlaps between the BLS major occupation groups and the New Hampshire CMHC direct services cohorts: for example, the major occupational category of Community Health Workers<sup>2</sup> may include CMHC staff with waivers and case managers. There is some evidence to support this overlap<sup>xvi</sup>, however, it is also possible that such inferences may not be accurate. The inability to compile and compare detailed, complete estimates for employment in outpatient mental health and substance abuse centers across states highlights the need for enhanced data collection efforts.

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<sup>2</sup> According to the Bureau of Labor Statistics, Occupational Employment Statistics, Community Health Workers “Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.” This definition was retrieved from <https://www.bls.gov/oes/current/oes211094.htm>

**Table 1: Estimated students/residents per provider at elementary and secondary schools/outpatient mental health centers, New Hampshire and neighboring states, 2016**

	NH	MA	ME	VT
<i>Estimated elementary and secondary school students per provider for school behavioral health workers</i>				
Social workers	2,221	450	375	642
Psychologists	1,269	476	3,529	701
Registered nurses	378	338	401	266
Counselors	217	230	226	179
<i>Estimated residents per provider for outpatient mental health and substance abuse centers</i>				
Social workers	7,025	3,870	3,096	1,059
Community health workers	22,247	*	*	6,246
Counselors	1,934	2,263	4,035	1,602
Registered nurses	13,348	11,353	7,832	20,820
Nurse practitioners	*	52,398	22,191	*
Licensed practical and licensed vocational nurses	*	28,382	*	*
Psychiatrists	33,370	61,925	*	*
Psychologists	*	11,950	33,287	8,923
Family and general practitioners	*	136,236	*	*
Medical assistants	*	75,686	*	*
Healthcare support occupations	*	52,398	9,511	*

\* BLS estimate is not available.

Data sources include the Bureau of Labor Statistics May 2016 OES Research Estimates by State and Industry, state Department of Education enrollment data for the 2015-2016 school year, and U.S. Census 2016 state population data. A complete list of data sources and the methodology used when creating these estimates is presented in the notes section.<sup>xvii</sup>

While it was not possible to create useful regional and national estimates for students/residents per provider in each of the occupations displayed in Table 1, existing data do highlight the scarcity of one position - school psychologists - nationwide. The National Association of School Psychologists recommends a district ratio of 500-700 students per school psychologist. However, in many states that ratio is closer to 2,000:1 and in some states it is as high as 3,500:1.<sup>xviii</sup> An estimate of school psychologists per elementary and secondary students in New Hampshire is 1,269 students per psychologist (Table 1). This is higher than the recommended ratio, but lower than many other states, including Maine. Notably, Table 1 estimates reveal that school social workers are particularly scarce in New Hampshire, with a ratio of 2,221 students per social worker. New Hampshire has less access to these workers than does Maine, Massachusetts, and Vermont.

Estimates of residents per provider for outpatient mental health and substance abuse centers reveal that New Hampshire outperforms two of the three neighboring states in residents-per-counselor, but fares worst in terms of residents-per-social worker. However, given uncertainty

regarding the types of behavioral health provider positions used in the centers across states and employment numbers in these positions, due to multiple unavailable estimates, these differences should be interpreted with caution.

In addition to tracking mental health provider shortages by geographic area (with a focus on provider shortages among the entire population of a geographic area), the Health Resources and Services Administration tracks shortages by population group (i.e., a shortage of providers for specific population groups such as low income, migrant farmworkers, etc., within defined geographic areas) and facility type (i.e., correctional facilities, state mental hospitals, and various other facilities lacking a sufficient number of providers). While all geographic and population shortage designations are assigned based on an application and scoring process, certain facilities (e.g., Federally Qualified Health Centers, Indian Health Facilities) are automatically classified as shortage areas based on current regulations and statutes. For areas, groups, and facilities that are subject to the application process, the primary eligibility criteria for a Health Professional Shortage Area (HPSA) designation is a threshold ratio for population to providers.<sup>xix</sup>

Table 2 displays designated Mental Health Care Professional Shortage Areas as of September 30, 2017, for New Hampshire, neighboring states, and regional comparisons. Detailed data on county location are also presented in Table 2 for each shortage designation type in New Hampshire. While New Hampshire has fewer total shortage designations than neighboring states, it is also the smallest of the four states in geographic area and has a population that is less than a quarter as large as the population of Massachusetts.<sup>xx</sup> Within New Hampshire, more shortage areas (geographic and facility) exist in Coos county than in any other county.

**Table 2: Mental Health Care Professional Shortage Areas, September 2017**

Designation type	Number of designations					
	National	New England	NH	MA	VT	ME
Geographic area	1,052	25	3	1	0	12
Population group	312	9	0	4	0	0
Facility	3,452	163	17	51	24	39
<b>New Hampshire shortage designation detail, by county</b>						
County	Geographic area designation		Facility designation			
Belknap	1		-			
Coos	2		5			
Grafton	-		3			
Hillsborough	-		3			
Merrimack	-		1			
Rockingham	-		2			
Strafford	-		1			
Sullivan	-		2			
<b>Total</b>	<b>3</b>		<b>17</b>			

Source: Health Resources & Services Administration. (2017). Shortage areas. Designated Health Professional Shortage Areas Statistics as of September 30, 2017. Retrieved October 24, 2017 from <https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx>

New Hampshire fares worse than neighboring states in terms of practicing child and adolescent psychiatrists. Table 3 displays the number of practicing child and adolescent psychiatrists per child age 0-17 for New Hampshire and neighboring states. A total of 42 states, including New Hampshire, are classified by the American Academy of Child & Adolescent Psychiatry as having a severe shortage of practicing child and adolescent psychiatrists, with at least 5,559 children per practitioner.<sup>xxi</sup>

**Table 3: Children per practicing child and adolescent psychiatrist in New Hampshire and neighboring states, with regional comparisons, in 2015**

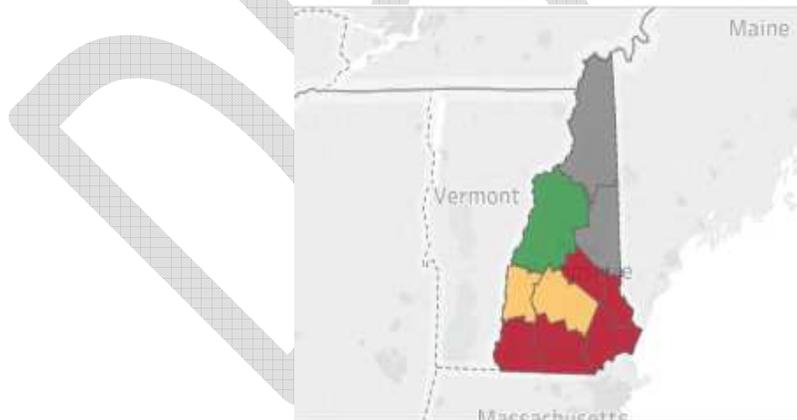
State or region	Children age 0-17 per practicing child and adolescent psychiatrist
NH	5,568
MA	3,146
ME	4,777
VT	4,060
New England average	4,015
National average, not including D.C.*	10,292

\* Washington, D.C. is the only area nationwide receiving a “mostly sufficient supply” designation, with 1,797 children age 0-17 per practicing child and adolescent psychiatrist, and is therefore considered an outlier.

Source: American Academy of Child & Adolescent Psychiatry. (2015). Workforce maps by state. Retrieved from [http://www.aacap.org/aacap/Advocacy/Federal\\_and\\_State\\_Initiatives/Workforce\\_Maps/Home.aspx](http://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx)

In terms of children per practitioner, states range from a high of 22,961 children per practitioner in Wyoming to a low of 3,146 children per practitioner in Massachusetts. Overall, New Hampshire has 5,568 children per child and adolescent psychiatrist, which is higher than neighboring states. Figure 1 displays shortage data in New Hampshire by county. Severe shortage counties are shown in red, high shortage counties in yellow, and the county with mostly sufficient supply (Grafton) in green. Gray shading indicates the two counties (Coos and Carroll) in which there are no practicing child and adolescent psychiatrists.

**Figure 1: Practicing child and adolescent psychiatrists by New Hampshire county, 2015**



Source: American Academy of Child & Adolescent Psychiatry. (2015). Workforce maps by state. Retrieved from [http://www.aacap.org/aacap/Advocacy/Federal\\_and\\_State\\_Initiatives/Workforce\\_Maps/Home.aspx](http://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx)

As shown in Table 3 and Figure 1, a lack of providers is an issue in New Hampshire. The state has identified psychiatry as a critical healthcare field for which there is a shortage of providers.<sup>xxii</sup> In terms of wait lists, an Endowment for Health report on workforce challenges in

CMHC found wait lists for new patients ranging from 7-84 days across state CMHC.<sup>xxiii</sup> Another New Hampshire source cites anecdotal professional descriptions of long wait lists for an appointment with a child psychiatrist.<sup>xxiv</sup> A Children's Hospital Association study and multiple state studies similarly cite long wait times for appointments in clinics and with children's behavioral health professionals across the nation.<sup>xxv</sup> State and nationally-focused sources also highlight the limited supply of providers and find that supply is not growing to meet demand.<sup>xxvi</sup> However, there is not enough data available to situate New Hampshire within the national landscape.

### *Remuneration*

SAMHSA has found that, generally, behavioral health professionals earn lower salaries than professionals in comparable health care sectors and in business.<sup>xxvii</sup> In a 2011 survey of nearly 2,000 community-based, mainly nonprofit providers of mental health and substance abuse services, the National Council for Community Behavioral Healthcare (NCCBH) found that a licensed professional social worker (a position that typically requires a Master's degree and 2,000 hours of post-graduate experience) earned less than a manager of a fast food restaurant.<sup>xxviii</sup> The survey results showed a positive association between organizational size/revenue and worker salaries. Geographic location also impacted salary, for example, with psychiatrists in rural areas earning more than those working elsewhere.<sup>xxix</sup>

Low pay is cited as a deterrent to attracting medical and Ph.D. students to this field, particularly when students must repay significant student loan debt.<sup>xxx</sup> For individuals currently in the behavioral health workforce, low salaries are one factor that is associated with low morale, low levels of commitment to the field and to employers, and high turnover.<sup>xxxi</sup>

A recent study of the CMHC workforce in New Hampshire found that salary is a key factor related to staff satisfaction.<sup>xxxii</sup> Between 2010 and 2014, only 3 of the 12 position categories reviewed experienced salary increases relative to inflation. The positions for which pay improved relative to the inflation rate were MD psychiatrist, licensed psychologist, and licensed clinic-based staff with a Master's degree. The median pay for other positions, including support staff, program directors, and unlicensed clinic-based staff with a Master's degree, did not increase relative to the inflation rate. The study found that typical salaries for many CMHC direct services staff were much lower than what they could earn in regional hospitals, schools, and private practices.<sup>xxxiii</sup>

BLS data allowed for a comparison of behavioral health salary estimates for positions in New Hampshire to those in other states. Table 4 presents salary estimates for the two most prevalent elementary and secondary school behavioral health positions, and the two most prevalent positions at outpatient mental health and substance abuse centers, in New Hampshire.<sup>xxxiv</sup> Comparisons to neighboring states, New England, and national estimates are presented in Table 4 as well. Salary estimates are also shown as a percent of the federal poverty level, and state living wage levels are given for comparative context. The federal poverty threshold is adjusted annually, is the same for the contiguous 48 states, and is used to determine eligibility for certain federal programs, like Medicaid.<sup>xxxv</sup> This measure solely takes into account costs associated with a basic food budget. Alternately, living wage calculations are presented by state and region, and

incorporate family costs related to multiple necessities (e.g., food, housing, health insurance, and child care) to determine the amount necessary to meet these needs.<sup>xxxvi</sup> In general, Massachusetts salary estimates are highest, while New Hampshire falls in the middle relative to its neighbors. Salary estimates for school counselors and nurses typically fall well above living wage levels, but are below 250% of the poverty level in all states except for Massachusetts. In outpatient mental health and substance abuse centers, estimates fall closer to a living wage and are often below 200% of the poverty level.

Notably, the median social worker wage in New Hampshire outpatient mental health and substance abuse centers falls at 197% of the federal poverty level. The median mental health counselor wage in New Hampshire is slightly lower, at 176% of the federal poverty level.

Outside of these two most prevalent positions in outpatient mental health and substance abuse centers, BLS salary estimates in New Hampshire vary widely. For example, community health workers in centers in the state are estimated to earn a median annual income of just \$30,460 annually, while registered nurses in the centers are estimated to earn a higher median annual income of \$59,050. Community health workers appear to have the lowest median income of direct care workers at New Hampshire centers.<sup>xxxvii</sup> There is some evidence that the umbrella occupational category of “community health workers” includes positions such as case managers and family support workers<sup>xxxviii</sup> – two job titles that are similar to those comprising the “case manager” job category in Antal’s 2016 study of New Hampshire CMHC.<sup>xxxix</sup> Antal’s data on 7 of the 10 New Hampshire CMHC show that roughly 31% of direct services staff are case managers.<sup>xl</sup> This suggests that New Hampshire CMHC may rely on a relatively low-paid category of staff for nearly a third of the workforce. Nationally, BLS estimates of employment growth find that community health worker positions are projected to grow by 16% between 2016 and 2026. This is slightly larger than projected growth rates for psychologists (14%) and social workers (15%) during the same time period, and more than double the predicted 7% growth rate for all occupations.<sup>xli</sup> Given the large amount of projected growth in this occupational category, it may be beneficial to perform more targeted research on the role of community health workers in New Hampshire CMHC.

### *Staff turnover*

Turnover creates costs to employers (i.e., hiring and training new workers) and patients (i.e., disruption to the therapeutic relationship). Further, remaining workers in organizations with high turnover experience greater stress and increased demands on their work time.<sup>xlii</sup> A variety of factors contribute to turnover in the mental health workforce. These include stress, burnout, little social support, organizational culture and climate, low salaries, and better opportunities elsewhere.<sup>xliii</sup> For addiction counselors, the stigma associated with addiction and working with addicts constitutes another factor.<sup>xliv</sup> Beyond these factors, the demographics of the workforce suggest increased turnover in coming years as aging mental health professionals approach retirement.<sup>xlv</sup>

Multiple studies have estimated turnover among behavioral health workers in the past 10-15 years. Generally, turnover in this workforce is high relative to turnover in other health professions. For child welfare social service workers, turnover is estimated at between 30 and 40

percent.<sup>xlvi</sup> A two-year study of over 700 clinicians in public and private treatment organizations found that clinical supervisors had a turnover rate of 23.4 percent, and counselors had a greater turnover rate of 33.2 percent.<sup>xlvii</sup> Clinicians and clinical supervisors were found to have turnover rates of 31 and 19 percent respectively in another study of adolescent treatment programs. This data was presented in comparison to much lower turnover rates among PCPs in managed care organizations (median turnover rate of 7.1 percent) and nurse practitioners and physician assistants (turnover rates of 12 percent).<sup>xlviii</sup>

Multiple New Hampshire studies have found high turnover rates among staff at state CMHC.<sup>xliv</sup> Antal (2016) surveyed both CMHC directors and staff for feedback on turnover, reporting that directors commonly cited competition with schools/private practices, state documentation requirements, and low salaries relative to the cost of living as major barriers to employee retention. Further, he found that over 50 percent of staff identified the following four areas as major concerns related to their job satisfaction: low salaries relative to cost of living, no step raises, excessive documentation requirements, and budget issues that limit community services to clients.<sup>1</sup> While data on behavioral health staff turnover in schools are unavailable, a 2009 report on children's mental health services in the state notes that turnover among school mental health professionals is a significant concern, especially in rural areas.<sup>li</sup>

Recent reports from neighboring states Massachusetts and Vermont cite high turnover among behavioral health staff as a major concern as well. Factors contributing to turnover in these states include low wages, administrative demands, and providers' debt loads upon graduation from school.<sup>lii</sup> The data on turnover in other states and nationally are incomplete, therefore direct comparisons with New Hampshire are not possible.

**Table 4: Salary estimates for the most prevalent positions in New Hampshire elementary and secondary schools and outpatient mental health and substance abuse centers, with comparison to neighboring states and regional comparisons, 2016**

<b>Elementary and secondary schools</b>					
State or region	State living wage <sup>1</sup>	<i>Counselors</i>		<i>Nurses</i>	
		Mean annual salary (\$)	Median annual salary (\$)	Mean annual salary (\$)	Median annual salary (\$)
NH	32,469	60,250	60,370	58,360	57,420
Percent of poverty level <sup>2</sup>		248%	248%	240%	236%
MA	35,006	75,400	73,840	70,570	68,350
Percent of poverty level		310%	304%	290%	281%
ME	31,990	55,080	54,750	50,720	49,220
Percent of poverty level		227%	225%	209%	203%
VT	34,070	60,400	58,760	56,450	54,840
Percent of poverty level		249%	242%	232%	226%
New England <sup>3</sup>		66,688	67,105	61,483	58,300
National <sup>3</sup>		61,855	60,920	56,134	54,660
<b>Outpatient mental health and substance abuse centers</b>					
State or region	State living wage <sup>1</sup>	<i>Mental health counselors</i>		<i>Mental health and substance abuse social workers</i>	
		Mean annual salary (\$)	Median annual salary (\$)	Mean annual salary (\$)	Median annual salary (\$)
NH	32,469	44,770	42,750	49,260	47,950
Percent of poverty level <sup>2</sup>		184%	176%	203%	197%
MA	35,006	48,160	43,260	46,170	41,820
Percent of poverty level		198%	178%	190%	172%
ME	31,990	47,490	48,220	61,310	55,600
Percent of poverty level		195%	198%	252%	229%
VT	34,070	38,280	36,750	40,400	36,800
Percent of poverty level		158%	151%	166%	151%
New England <sup>3</sup>		47,040	43,125	49,472	45,470
National <sup>3</sup>		45,662	42,750	43,941	38,300

<sup>1</sup> State living wage is shown for a family of 4, with two working adults and two children, in 2016.<sup>liii</sup>

<sup>2</sup> State salary estimates are presented as a percentage of federal poverty-level income of \$24,300 for a family of 4 in 2016.<sup>liv</sup>

<sup>3</sup> New England and national mean annual salaries were calculated by taking the average of the state average annual salary data (i.e., the mean of the state means); median annual salaries were calculated by taking the median of the state median annual salary data (i.e., the median of the state medians). See notes section for detailed occupational category and sample information.<sup>lv</sup>

Source: Bureau of Labor Statistics OES Research Estimates by State and Industry, May 2016

### *Uncompensated care*

Uncompensated care has been identified as an issue affecting behavioral health providers nationwide. For psychiatrists, reimbursement amounts from Medicare, Medicaid, and private insurance companies often do not cover the provider's costs.<sup>lvi</sup> Low reimbursement rates are directly associated with the disproportionately low incomes generated by psychiatrists relative to other medical specialists.<sup>lvii</sup> Pediatricians, who are increasingly diagnosing and treating mental health conditions, have expressed concern about managed care reimbursement policies. Typically, they are not reimbursed for time spent talking to a child's family and teachers in order to determine whether a child has a certain disorder, and may not be reimbursed for time spent advising children and their families about their conditions.<sup>lviii</sup>

State-specific publications point to uncompensated care caused by low reimbursement rates as being problematic for providers. A 2014 report to the Texas legislature notes that "The Texas Medical Association, the Federation of Texas Psychiatry, and the Texas Pediatric Society ... jointly authored a letter calling the issue of low reimbursement rates 'the elephant in the room' when addressing the mental health workforce shortage" and states that "... current reimbursement rates for licensed professional counselors, clinical social workers, marriage and family therapists, psychologists, and psychiatrists often fail to match provider costs when providing individual therapy."<sup>lix</sup>

In Massachusetts, a survey of licensed mental health providers found that many who chose not to participate on insurance panels cited low reimbursement rates and a substantial amount of time spent on unreimbursed care as reasons for this choice.<sup>lx</sup> The survey also found that child practitioners spent between 7 and 12 percent of their time on unreimbursed consultations necessary to diagnose and treat patients. This was substantially more time than was spent by the adult providers in the survey; however, families, researchers, and clinicians argue that children may require significantly more of this time to ensure effective treatment.<sup>lxi</sup>

A recent (2016) report estimates that uncompensated New Hampshire CMHC care comprises between 5 and 12 percent of total expenses.<sup>lxii</sup> Recent annual spending on uncompensated care (formally classified as unreimbursed charity care) for 9 of the 10 state CMHC is displayed in Table 5.

**Table 5: New Hampshire CMHC uncompensated charity care costs, for the most recent fiscal year available**

<b>CMHC Name</b>	<b>Unreimbursed charity care (\$)</b>	<b>Fiscal year</b>
<b>Northern Human Services</b>	2,373,009	2015-2016
<b>Riverbend Community Mental Health Center</b>	2,282,469	2016-2017
<b>Center for Life Management</b>	2,079,272	2016-2017
<b>Mental Health Center of Greater Manchester</b>	1,539,392	2016-2017
<b>Community Partners</b>	1,112,400	2016-2017
<b>Monadnock Family Services</b>	831,718	2016-2017
<b>Greater Nashua Mental Health Center at Community Council</b>	815,941	2016-2017
<b>Genesis Behavioral Health</b>	576,170	2016-2017
<b>West Central Behavioral Health</b>	517,246	2016-2017

Note: Data were not available for Seacoast Mental Health Center.

Source: Community Benefit Plans submitted to the New Hampshire Department of Justice, available at <https://www.doj.nh.gov/charitable-trusts/community-benefits/index.htm>

### *Licensing reciprocity*

Licensing reciprocity varies by state and profession. Examples of this variation are presented below for five different behavioral health professions: physicians, psychologists, social workers, professional school counselors, and school psychologists. Some professions have no licensing reciprocity, others do, and others benefit to some extent from programs aimed to facilitate ease of license transfer between states.

Currently, 18 states participate in the Interstate Medical Licensure Compact (IMLC), which offers an expedited route to licensure for physicians who wish to practice in more than one state. New Hampshire became a participant in 2016, and one neighboring state (Maine) has initiated legislation to become a participant.<sup>lxiii</sup> Under the IMLC, physicians who meet eligibility requirements can qualify to practice in participating states. The mission of the IMLC is “to increase access to health care for patients in underserved or rural areas” and allow them to “more easily connect with medical experts through the use of telemedicine technologies.”<sup>lxiv</sup> The Compact has been praised by the American Academy of Pediatrics as a way of potentially “Extending the expert reach of pediatric subspecialties whose numbers may be small or not widely distributed (e.g., ... child and adolescent psychiatry, etc.)”.<sup>lxv</sup>

For the psychology profession, the Association of State and Provincial Psychology Boards (ASPPB) has established an Agreement of Reciprocity (AOR), which is “a cooperative agreement whereby any individual holding a license in one AOR participating jurisdiction may obtain a license to practice in another AOR participating jurisdiction.”<sup>lxvi</sup> Four states (Arkansas, Missouri, Nebraska, and Texas) currently participate in this program.<sup>lxvii</sup> The ASPBB has also created the Psychology Licensure Universal System (PLUS) program to enable psychology professionals to easily apply for licensure, certification, or registration in participating states, provinces, and territories in the U.S. and Canada.<sup>lxviii</sup> Currently, 12 state boards of

psychologists/examiners of psychologists (including New Hampshire's) participate in the PLUS program, and 5 other states are slated to join in the near future.<sup>lxi</sup> None of New Hampshire's neighboring states participate in this program. The ASPPB is also working on an E.Passport program to enable licensed psychologists to more easily practice telepsychology across state lines.<sup>lxx</sup>

According to the Association of Social Work Boards (ASWB), no U.S. states have reciprocity for social work licensure.<sup>lxxi</sup> The ASWB has created a Social Work Registry to enable professionals to create a permanent record of primary source materials (e.g., education transcripts, social work examination scores, verification of clinical supervision) that can be sent to state regulatory boards as part of a licensure application.<sup>lxxii</sup>

The American Counseling Association surveyed state education agencies in 2011 to examine differences in regulations on professional school counseling. All states require professional school counselors to have graduate education in school counseling, and many require additional credentials (e.g., specific coursework or completion of an internship or practicum). Thirty-eight states, including New Hampshire, Massachusetts, Maine, and Vermont, recognize school credentials from other states. Each of these state's reciprocity regulations are slightly different.<sup>lxxiii</sup>

School psychologist credentialing requirements vary across states. The National Association of School Psychologists is working to create national standards for credentialing professionals in this field. This organization offers a Nationally Certified School Psychologist (NCSP) credential to psychologists who meet educational and continuing professional development standards. Thirty-one states "acknowledge, recognize, or accept the NCSP as either meeting or partially meeting requirements for the state school psychologist credential."<sup>lxxiv</sup> Vermont, Maine, and Massachusetts recognize this credential (with Massachusetts requiring additional state exams for credentialing), however New Hampshire does not recognize the NCSP credential.<sup>lxxv</sup>

### Barriers to sufficient staffing levels and strategies to address staff shortages

Insufficient staffing leads to long wait lists for care, and to more children and adults living with untreated health issues. A 2004 journal article reported that nationally "... only about 20 percent of youth with emotional and behavioral needs are receiving mental health care."<sup>lxxvi</sup> States are citing the impact of insufficient staffing as well. For example, due to a provider shortage in Wisconsin, almost 100,000 children in the state are estimated to be living with untreated mental health issues.<sup>lxxvii</sup> The Maine Behavioral Health Community Collaborative has projected that due to 200 vacant positions in the community mental health system, over 1,300 children and adults are not being served.<sup>lxxviii</sup> In Texas, state officials have noted that despite a worsening shortage of mental health professionals, nationwide scarcity will make it difficult to recruit practitioners from other states.<sup>lxxix</sup>

Given the lack of behavioral health providers nationwide, there are a multitude of nationally-focused publications dedicated to exploring barriers to sufficient staffing levels as well as strategies to grow the workforce. Macro-level factors associated with insufficient staffing point to a growing demand for services and a small (and shrinking) supply of providers. Available

state-level publications generally echo national concerns, particularly around an aging workforce and a lack of new professionals training to step in as current providers retire.

### *National barriers to sufficient staffing levels*

In terms of demand, the number of children under age 18 in the United States has been predicted to grow from 72 million in 2000 to 83 million by 2030.<sup>lxxx</sup> At the same time, increasing numbers of young children are being referred for mental health services, as evidence suggests an increasing occurrence of emotional disorders in this population.<sup>lxxxii</sup> Further, geographic constraints prevent children in rural areas and areas of low socioeconomic status from accessing behavioral health services.<sup>lxxxii</sup>

Provider supply is inadequate to meet demand, for the following reasons:

#### *The current workforce is aging.*

In most mental health professions, well over half of clinically trained workers are older than 50, and many of the leaders in the behavioral health field are approaching retirement.<sup>lxxxiii</sup> Almost 55 percent of psychiatrists are over age 55.<sup>lxxxiv</sup>

#### *Training is falling short in multiple ways.*

First, training programs are out of sync with changes in policy and practice related to delivering services to children and families. Huang et al. (2004) note that “There are concerns within the children’s mental health field that pre-service academic training bears little relation to the demands of the actual work in the community, the changing models of service delivery, and the comprehensive approaches necessary to meet the needs of the children and families.”<sup>lxxxv</sup>

Second, even though there is an acute need for rural providers, there is a lack of focus on rural behavioral health service delivery in most training programs.<sup>lxxxvi</sup> Third, there is a lack of training among non-specialist providers offering mental health treatment to children (e.g., pediatricians and family physicians), and many pediatricians do not have access to psychiatrist consultation regarding treatment, especially in New Hampshire.<sup>lxxxvii</sup>

#### *Fewer physicians specialize in child and adolescent psychiatry.*

Just 4 percent of medical school graduates apply to residency programs in psychiatry.<sup>lxxxviii</sup> Most medical students in the United States have little or no clinical or clerkship experience in child and adolescent psychiatry.<sup>lxxxix</sup> Financial disincentives to pursuing this career path are cited as a primary reason for shrinking interest. Salaries and reimbursements for psychiatrists are low compared to other fields of medicine, and increasing educational debt and long training periods dissuade students from entering the profession.<sup>xc</sup>

#### *Lack of diversity.*

More than half of U.S. children are expected to be part of a racial or ethnic minority group by the year 2020.<sup>xcii</sup> However, few behavioral health providers come from diverse backgrounds (e.g., 6, 13, and 21 percent of psychologists, social workers, and psychiatrists, respectively).<sup>xcii</sup> As Hoge et al. (2013) note, “The low rates of diversity in the workforce are troubling since evidence suggests that minority health professionals are more likely than others to serve people of color. In addition, health care consumers who share a culture and race with a provider develop a

stronger therapeutic alliance and have higher treatment retention rates, compared to consumers who are from a different culture and race than their provider.<sup>xxciii</sup>

Turnover is high.

The reasons for, and effects of, high turnover rates in the behavioral health workforce are discussed in the *Staff Turnover* section above.

Workforce data are lacking.

An overarching concern relates to the lack of data on the workforce and workforce development strategies, and a reliance on anecdotal evidence.<sup>xciv</sup> In their discussion of the development of a minimum data set for the behavioral health workforce, Beck et al. (2016) identify effective workforce planning as a “key challenge in the field of behavioral health” and find that, “the field [of mental health provision and substance use disorder services] lacks comprehensive data accurately describing the size, composition, and characteristics of the numerous disciplines comprising the behavioral health workforce, which is a barrier to workforce development and planning.”<sup>xcv</sup>

### *Barriers to sufficient staffing levels in New Hampshire*

New Hampshire staffing concerns are particularly acute in rural areas, since half of all practicing child psychiatrists are concentrated in two southeastern counties, and two northeastern counties (Coos and Carroll) lack any practicing child psychiatrists.<sup>xcvi</sup> Relative to the other three most northern New England states, New Hampshire has the largest number of children per psychiatrist.<sup>xcvii</sup> Coos county and Carroll county also have fewer licensed psychologists than the state average of 3,333 or fewer residents per psychologist.<sup>xcviii</sup>

State policy has been identified as a barrier to sufficient staffing in New Hampshire. Policy and legislative barriers reduce staff efficiency by directing job responsibilities (e.g., determining who is allowed to approve a plan for treatment; ineffectively coordinating and billing services across mental health providers). This leads to high turnover rates, which in turn increase pressure on remaining staff members.<sup>xcix</sup> Further, state licensure rules can prevent qualified providers from being able to work, and can in some cases impede billing for services.<sup>c</sup>

The lack of high-quality, complete workforce data is a major barrier to determining the adequacy of staffing levels in the New Hampshire behavioral health workforce. Discussing the scarcity of data in the state, Norton et al. (2007) present this difficulty in the context of a shifting workforce landscape:

Despite the lack of a reliable, uniform data [sic] on the mental health workforce, experts have consistently reported a critical shortage of qualified children's mental health providers in most practice areas: private practice, community clinics, public hospitals, and public mental health care systems that aim to keep troubled children and youth in the community.

However, there is a wider variety of mental health providers than ever before, and a number of professions are in the process of redefining their roles. These shifts have been driven by a variety of different factors including changes in

clinical practices, trends toward the use of professionals who are not specially trained in the field of children's mental health, and a major shift away from using psychiatric hospitals for seriously disturbed children. These changes, combined with the evolution of best practices and what is considered effective care, make it difficult to assess the workforce needs of the behavioral health community. (page 13)

Despite a lack of complete and reliable data, there is a broad-based understanding in New Hampshire, other states, and across the nation that the shortage of providers will intensify in coming years. Multiple strategies to address staff shortages have been described in the literature, as presented below.

### *National strategies to address staff shortages*

Publications with a national focus commonly describe expanding and building capacity in the current behavioral health workforce as a strategy for addressing staff shortages. Strategies to enhance training, recruitment, and retention are also common, with some specific attention given to improving diversity in the workforce. Additionally, the importance of expanding and improving data collection to inform workforce development efforts is discussed. Major topics of discussion in the national literature are presented below.

#### *Expand and build capacity in the current workforce.*

Proposals to expand the current behavioral health workforce recognize that PCPs are increasingly delivering prevention, screening, and treatment services, and need training and technical assistance in this regard.<sup>ci</sup> Behavioral health providers may act as consultants to PCPs in a team-based care approach.<sup>cii</sup> The Massachusetts Child Psychiatry Access Program is one example of a successful model of children's behavioral health consultation support to PCPs. This program provides services to all Massachusetts children and families, free of charge, through their PCPs.<sup>ciii</sup> Beyond PCPs, social workers have been identified as playing an important potential role in patient assessment, early detection and intervention, and referral to other providers.<sup>civ</sup>

The Annapolis Coalition on the Behavioral Health Workforce (2007) identifies individuals and their families (as appropriate) as an underutilized resource that can be used to direct their own care, provide peer support to others, and educate the workforce.<sup>cv</sup> More broadly, paraprofessionals, school personnel, kinship members involved in wraparound approaches, foster parents in treatment foster care programs, and volunteer and professional mentors have been noted as emerging providers of children's behavioral health care.<sup>cvi</sup> New providers can expand the capacity of the system, but will require appropriate training (e.g., through community colleges, state maternal and child health divisions, child welfare agencies, faith-based organizations, and community organizations) in order to deliver high-quality care.<sup>cvii</sup>

To address the shortage of psychiatrists in state hospitals and community health programs, some states have opted to allow psychologists to prescribe medications, provided that they complete a specialized training program.<sup>cviii</sup> New Mexico was the first state to enact a law, in 2002, allowing specially trained psychologists to prescribe psychotropic medications.<sup>cix</sup> The law was made in an

attempt to increase access to care in rural areas, since a large number of rural schools employ psychologists in the state.<sup>cx</sup> Louisiana enacted a similar law in 2004, followed by Illinois in 2014 and Iowa in 2016.<sup>cx</sup> Psychiatrists and the National Alliance for the Mentally Ill have concerns about this practice, rooted in a worry that the amount of specialized training required is not adequate to ensure proper oversight of patient medications.<sup>cxii</sup>

Capacity can also be developed through enhanced use of technology. For example, the development of a technical assistance infrastructure could support the workforce with information and guidance, manage work flow, reduce administrative burdens, guide the implementation of best practices, and track key workforce issues.<sup>cxiii</sup> Further, information technology could also be used to coordinate care provision between multiple providers and support multidisciplinary teams.<sup>cxiv</sup> Telehealth and teleconsultation practices can also be used to extend the reach of providers.<sup>cxv</sup>

#### Enhance training.

Strategies to enhance behavioral health training include putting a focus on evidence-based teaching and the development of core competencies that are required throughout the workforce and shared across different sectors in the field.<sup>cxvi</sup> Training should incorporate newer concepts in the field, such as a focus on child and family strength, improving functional status, and the adoption of evidence-based treatment approaches for substance use disorders in youth.<sup>cxvii</sup> Information technology can be used to improve access to training.<sup>cxviii</sup>

Huang et al. (2004) put forth specific strategies to improve behavioral health workforce training for different types of organizations. For example, state human service agencies can develop and adopt cross-agency workforce strategic plans with input from stakeholders. These plans could create a strategy for training a competent children's behavioral health workforce and foster the design of standard curricula and development of an infrastructure to deliver training across systems. Postsecondary schools can engage with stakeholders to develop pre-service coursework that is aligned with current technologies and timely content, e.g., system of care values and principles in practice. The children's divisions of professional associations and organizations can solicit and use practitioner feedback to ensure that they are providing in-demand training on newer technologies and service delivery models.<sup>cxix</sup>

#### Improve recruitment and retention efforts.

In order to counterbalance the aging workforce, efforts must be made to recruit new students into behavioral health fields.<sup>cxx</sup> The Annapolis Coalition on the Behavioral Health Workforce (2007) recommends that states and local organizations use a "grow-your-own" strategy to recruit and develop the behavioral health workforce. This involves "... engaging local residents in entry-level positions and promoting their long-term professional growth, development, and advancement within the organization or system of care."<sup>cxxi</sup>

Recruitment efforts may also involve financial incentives related to education. This could include training stipends, scholarships, and tuition assistance, particularly for graduates who agree to work in underserved geographic areas.<sup>cxvii</sup> Many states use student loan repayment as an incentive to enhance provider coverage in shortage areas, with varied criteria and repayment

amounts. Minnesota operates a mental health professional loan forgiveness program in both rural and urban areas, with the purpose of addressing shortages in certain areas and facilities. The program applies to a number of licensed professionals, including psychiatrists, psychologists, and psychiatric nurse specialists/nurse practitioners. Loan repayment amounts vary, with participants in the aforementioned professions receiving \$12,000 annually.<sup>cxxiii</sup> Texas offers a significantly greater repayment amount through the Physician Education Loan Repayment Program. Participating psychiatrists or PCPs receive \$160,000 (equivalent to \$40,000 annually) for agreeing to spend four years practicing in a Health Professional Shortage Area.<sup>cxxiv</sup>

Wages are an important factor in both recruitment and retention, and should be commensurate with education, experience, and responsibilities.<sup>cxxv</sup> Additional factors involved in retention include career ladders, training opportunities, and other personal growth incentives.<sup>cxxvi</sup>

To develop a workforce that better reflects the children and families being served, state agencies can work with postsecondary schools to actively recruit students from diverse ethnic and racial backgrounds into human services degree programs.<sup>cxxvii</sup> Additionally, parents and youth from diverse cultures can be engaged as instructors for in-service training programs.<sup>cxxviii</sup>

### *Strategies to address staff shortages in New Hampshire*

Several strategies to address staff shortages have been proposed or implemented in New Hampshire. These strategies involve enhanced training, financial incentives, streamlined licensure and certification requirements, utilization of psychiatric mental health nurse practitioners to build clinical capacity, and improved data collection to inform workforce development and expansion efforts.

Multiple studies recommend that the state enhance training resources and infrastructure to support staff in children's mental health agencies.<sup>cxxix</sup> A 2016 report to Governor Hassan entitled *Recommendations on Health Care and Community Support Workforce* finds that:

Successful programs to support educational advancement at all health care provider levels have been developed in the State using grants and other funding sources, only to be terminated for lack of ongoing financial support. This, among other factors, has led to a shortage of training programs at the direct care provider, licensed nursing assistant, and practical nurse levels. ... For students who are able to find appropriate education, effective transition to work is also compromised. Internships and apprenticeships in clinical facilities and in the community are scarce, and are leading to a delay in the development of "career ready" personnel. The shortage of opportunities for transitional education not only impacts quality of care directly, but also contributes significantly to role satisfaction, workforce recruitment, and workforce retention. (page 8)

It is important to note that New Hampshire is actively working to enhance training in several ways. For example, in 2012, the New Hampshire Children's Behavioral Health Core Competencies Leadership team published a set of state Children's Behavioral Health Core Competencies. These competencies, developed in conjunction with the state's 10 CMHC,

provide a unified structure for training and other aspects of professional development (e.g., recruitment, supervision, and retention) for direct service and supervisory staff in the behavioral health system.<sup>cxxx</sup> Another example is the Institutions of Higher Education Workgroup, which creates postsecondary coursework to teach students about the children’s behavioral health competencies and the principles and values of the behavioral health system of care.<sup>cxxxii</sup>

As described above, financial incentives are another aspect of employee retention. A survey of direct services staff at New Hampshire CMHC found that the top three factors that would be associated with a decision to stay with their agency for more than three years were, “regularly scheduled raises, cost of living increases, and loan forgiveness for practice in federally underserved areas.”<sup>cxxxiii</sup> Research in the state also finds that non-competitive wages deter potential providers from entering the behavioral health workforce.<sup>cxxxiii</sup>

New Hampshire has a loan repayment program for mental health professionals, with a focus on enhancing care in shortage areas, for medically underserved populations, and at organizations/facilities funded by programs in the Department of Health and Human Services. Eligible professions include psychiatrists, psychologists, psychiatric nurse specialists, and licensed clinical social workers. Participants must agree to three years of full-time service or two years of part-time service. Loan repayment amounts vary, with full-time psychiatrists receiving the maximum amount of \$75,000 and the other behavioral health professionals listed above receiving \$45,000.<sup>cxxxiv</sup>

In New Hampshire, varied and complex licensure and certification requirements have been identified as causing problems in recruiting and hiring staff.<sup>cxxxv</sup> This suggests that streamlining current requirements could enhance recruitment and retention efforts.

Differences in state policy delineate the use of different types of providers and provider support systems (e.g., allowing psychologists with advanced training to prescribe medication or creating a system of behavioral health consultation support to PCPs) to build capacity. In New Hampshire, incremental legislation has expanded the role of psychiatric mental health nurse practitioners (PMHNPs) in the state behavioral health system over the past 15 years. Currently, 49 PMHNPs (defined by state statute as advanced practice registered nurses, or APRNs) practice and provide clinical leadership alongside the 72 psychiatrists working at state CMHC and the state psychiatric hospital (New Hampshire Hospital).<sup>cxxxvi</sup>

Finally, enhanced data collection efforts could be used to gauge workforce adequacy and inform planning. In a 2016 report to Governor Hassan, the Governor’s Commission on Health Care and Community Support Workforce states that, “There is a paucity of data to document the size and capacity of the current health care workforce in New Hampshire, and to identify future workforce needs of the population. The Commission found that useful data on the healthcare and direct support workforce are scarce and, when available, are of poor quality.”<sup>cxxxvii</sup> This suggests the usefulness of increased data collection to inform future behavioral health workforce planning efforts.

As part of a demonstration project, the New Hampshire Delivery System Reform Incentive Payment (DSRIP) Program, in conjunction with statewide Integrated Delivery Networks, has

created a state behavioral health workforce capacity taskforce that is working to address many of the issues above. The taskforce is acting to bring together stakeholders to grow and develop the behavioral health workforce in New Hampshire through data collection, recruitment and retention efforts, training enhancement, and policy change.<sup>cxxxviii</sup>

## Discussion

This literature review suggests that New Hampshire is experiencing similar challenges to other states in recruiting and retaining a qualified behavioral health workforce. Nationally, the workforce is aging, turnover is high, recruitment efforts are lacking, and training is out of sync with the realities of service provision. A lack of sufficient behavioral workforce data is problematic everywhere.

Existing data allows for some comparison between New Hampshire, New England, and the nation. Population-to-provider and provider salary estimate comparisons between New Hampshire, New England, and the nation generally find New Hampshire faring better than the nation and worse than regional New England averages (Tables 4 and 5). Comparing New Hampshire to neighboring states on these metrics typically shows New Hampshire falling behind Massachusetts, and close to (in some cases doing worse than, in other cases slightly better than) Maine and Vermont (Tables 1, 4, and 5). In terms of estimated number of students per behavioral health provider (Table 1), New Hampshire mainly falls behind neighboring states. Salary comparisons show that New Hampshire school counselor and nurse salary estimates (Table 4) fall below Massachusetts, and are generally slightly higher than Maine and Vermont. Meaningful comparisons of residents per provider in outpatient mental health and substance abuse centers (Table 1) are difficult to make, due to the variation in types of providers employed at the centers. Given this variation, further research on the utility of the unique staffing structures and practitioner responsibilities employed by outpatient centers in other states could be used to adjust and improve staffing arrangements in New Hampshire centers. Salary estimates for the centers (Table 4) show that counselors and social workers in New Hampshire typically earn less than their counterparts in Maine but more than their similar workers in Vermont. Counselors in the centers earn less in New Hampshire than in Massachusetts, yet social workers earn more. An examination of children per practicing child and adolescent psychiatrist (Table 3) finds that New Hampshire fares worse than neighboring states.

Given the scarcity of existing data, compilation and analysis of comprehensive workforce data would be a productive next step for government and other stakeholders. The widely cited lack of workforce data currently inhibits planning and capacity-building efforts in New Hampshire. Research on useful and appropriate data collection to inform the development of a statewide behavioral health workforce data repository would provide a starting point for a broad-based collection and analysis effort. For example, the Behavioral Health Workforce Research Center at the University of Michigan has published an instrument to guide the collection of individual-level behavioral health care workforce data.<sup>cxxxix</sup> This research could be used to determine what individual-level data are needed, and how statewide data collection should proceed (e.g., a survey of behavioral health workers). Further data sources that would be useful to inform planning efforts in New Hampshire could be identified as well. This could include, for example,

BLS employment research estimates, NH Community Behavioral Health Association data on CMHC job vacancy rates, and the upcoming results of the NH DSRIP program's data collection initiatives (e.g., the compilation of a repository of integrated behavioral health care job descriptions, roles, and functions). The collection of comparative data (e.g., from neighboring states, New England, and the nation, to the extent possible) would be useful to provide relevant comparison groups when assessing New Hampshire's attractiveness to behavioral health professionals. The data repository could be analyzed and updated regularly to inform workforce planning and capacity-building efforts across the state.

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## Notes

- <sup>i</sup> See for example: Hoge, M., Stuart, G., Morris, J., Flaherty, M., Paris, M., & Goplerud, E. (2013). Mental health and addiction workforce development: federal leadership is needed to address growing crisis. *Health Affairs* 32(11): 2005-2012; The Lewin Group, Inc. & DMA Health Strategies. (2009).
- <sup>ii</sup> Beck, A., Singer, P., Buche, J., Manderschied, R., Buerhaus, P., Tuohy, C., & Boulton, M. (2016). A minimum data set for the behavioral health workforce. Ann Arbor, MI: Behavioral Health Workforce Research Center.
- <sup>iii</sup> American Hospital Association. (2016). *The state of the behavioral health workforce: a literature review*. Washington, DC: AHA.
- <sup>iv</sup> The Annapolis Coalition on the Behavioral Health Workforce. (2007). *An action plan for behavioral health workforce development*. Cincinnati, OH.
- <sup>v</sup> The Annapolis Coalition on the Behavioral Health Workforce. (2007).
- <sup>vi</sup> Hyde, P. (2013). *Report to Congress on the nation's substance abuse and mental health workforce issues*. Washington, DC: US Department of Health and Human Services.
- <sup>vii</sup> Health Resources & Services Administration. (2017, July 5). Table 1. Health professional shortage areas: number, population, and additional practitioners needed for geographic areas, population groups, and facilities as of July 5, 2017. Washington, DC: U.S. Department of Health and Human Services.
- <sup>viii</sup> Koppelman, J. (2004). *The provider system for children's mental health: workforce capacity and effective treatment*. NHPF Issue Brief No. 801. Washington, DC: National Health Policy Forum.
- <sup>ix</sup> American Hospital Association. (2016).
- <sup>x</sup> Koppelman, J. (2004).
- <sup>xi</sup> Texas Department of State Health Services. (2014). *The mental health workforce shortage in Texas*.
- <sup>xii</sup> The Primary Health Care Performance Initiative. (n.d.) Caseload per provider (daily). Retrieved from <http://phcperformanceinitiative.org/indicator/caseload-provider-daily#!loc=&viz=0&ci=false>
- <sup>xiii</sup> See for example Goldman, C., Faulkner, L., and Breeding, K. (1994). A method for estimating psychiatrist staffing needs in community mental health programs. *Hospital & Community Psychiatry* 45(4): 333-337.; Baker, J. (1997). A spreadsheet method for calculating maximum caseload and intake capacity for CMHC psychiatrists. *Psychiatric Services* 48(12):1578-1581.
- <sup>xiv</sup> Kaiser Family Foundation. (n.d.) Mental health care health professional shortage areas (HPSAs). Retrieved from <http://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- <sup>xv</sup> Antal, P. (2016). *Improving Child & Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers*. Retrieved from [http://www.endowmentforhealth.org/uploads/resources/id107/CMHC\\_Workforce\\_Full\\_Report\\_2016.pdf](http://www.endowmentforhealth.org/uploads/resources/id107/CMHC_Workforce_Full_Report_2016.pdf)
- <sup>xvi</sup> Ballester, G. (2005). *Community health workers: Essential to improving health in Massachusetts*. Findings from the Massachusetts community health worker survey. Boston, MA: Massachusetts Department of Public Health. This 2005 Massachusetts study of the broad occupational category of "community health worker" finds that this occupation is "used today as an umbrella term to describe members of the health workforce that function under a multitude of various job titles" (page 7). The study found that job titles which commonly fall under this umbrella include case managers and family support workers. In presenting a breakdown of the direct services workforce in 7

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New Hampshire CMHC in FY 2014, Antal (2016) classifies “case managers” as a category that includes functional family support case managers and staff with waivers (less than BA). See page 7.

<sup>xvii</sup> **Elementary and secondary school estimates** were created by taking a state’s K-12 school enrollment for the 2015-16 school year and dividing by BLS estimates of workers in each occupation at elementary and secondary schools in the state in May 2016. BLS data was obtained from OES Research Estimates by State and Industry, May 2016 at [https://www.bls.gov/oes/current/oes\\_research\\_estimates.htm](https://www.bls.gov/oes/current/oes_research_estimates.htm). Data was downloaded for Sector 61: Educational Services and filtered for North American Industry Classification System code 6111, Elementary and secondary schools. State K-12 school enrollment data was retrieved from the following sources: New Hampshire Department of Education Attendance and Enrollment Reports, 2015-2016, available at <https://www.education.nh.gov/data/attendance.htm>; Massachusetts Department of Elementary and Secondary Education Enrollment Data for 2015-2016, available at <http://www.doe.mass.edu/infoservices/reports/enroll/>; Maine Department of Education Data Warehouse Enrollment Data for 2015-2016, available at [http://dw.education.maine.gov/DirectoryManager/WEB/Maine\\_report/DTHome.aspx](http://dw.education.maine.gov/DirectoryManager/WEB/Maine_report/DTHome.aspx); Vermont Agency of Education Student Enrollment Data for 2015-2016, available at <http://edw.vermont.gov/REPORTSERVER/Pages/ReportViewer.aspx?%2fPublic%2fEnrollment+Report>.

**Outpatient mental health and substance abuse center estimates** were created by taking a state’s 2016 population and dividing by BLS estimates of workers in each occupation related to the direct provision of behavioral healthcare services in May 2016. BLS data was obtained from OES Research Estimates by State and Industry, May 2016 at [https://www.bls.gov/oes/current/oes\\_research\\_estimates.htm](https://www.bls.gov/oes/current/oes_research_estimates.htm). Data was downloaded for Sector 62: Health Care and Social Assistance and filtered for North American Industry Classification System code 1420, Outpatient mental health and substance abuse centers. Population data for 2016 was retrieved from U.S. Census Population Estimates, Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2016, available at <https://www.census.gov/data/tables/2016/demo/pepest/state-total.html>.

<sup>xviii</sup> Weir, K. (2012). School psychologists feel the squeeze. *Monitor on Psychology* 43(8): 34.

<sup>xix</sup> Health Resources & Services Administration. (2016). Health Professional Shortage Areas (HPSAs). Retrieved from <https://bhwh.hrsa.gov/shortage-designation/hpsas>

<sup>xx</sup> New Hampshire has a geographic area of 9,349 square miles, while neighbor states have geographic areas of 35,380 square miles (Maine), 10,554 square miles (Massachusetts), and 9,616 square miles (Vermont). In 2016, the Census Bureau estimated population for New Hampshire and neighbor states as follows: 1,334,795 (New Hampshire), 1,331,479 (Maine), 6,811,779 (Massachusetts), and 624,594 (Vermont). Data on state geographic areas were retrieved from the U.S. Census Bureau state area measurements, available at <https://www.census.gov/geo/reference/state-area.html>. State population estimates were retrieved from the U.S. Census Bureau annual estimates of the resident population of the United States, available at:

<https://www.census.gov/data/tables/2016/demo/pepest/state-total.html>

<sup>xxi</sup> “Severe shortage” is defined as having 1-17.99 practicing child and adolescent psychiatrists per 100,000 children age 0-17. As determined by the American Academy of Child & Adolescent Psychiatry, this category included all estimates of less than 18 practitioners per 100,000 children (this equates to more than 5,559 children per practitioner). Other classification categories include “High shortage” with 18-46.99 practicing psychiatrists per 100,000 children (i.e., between 2,128 and 5,559 children per practitioner) and “Mostly sufficient supply” with at least 47 practicing psychiatrists per 100,000 children (i.e., less than 2,128 children per practitioner). This data is from: American Academy of Child & Adolescent Psychiatry. (2015). Workforce maps by state. Retrieved from [http://www.aacap.org/aacap/Advocacy/Federal\\_and\\_State\\_Initiatives/Workforce\\_Maps/Home.aspx](http://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx)

<sup>xxii</sup> The Governor’s Commission on Health Care and Community Support Workforce. (2016). Recommendations on Health Care and Community Support Workforce. Retrieved from:

<https://www.dhhs.nh.gov/ombp/caremgmt/health-care/documents/hc-20161216-recommendations.pdf>

<sup>xxiii</sup> Antal, P. (2016).

<sup>xxiv</sup> Norton, S., Tappin, R., & McGlashan, L. (2007). Few and far between? Children’s mental health providers in NH. Concord, NH: New Hampshire center for public policy studies.

<sup>xxv</sup> Children’s Hospital Association. (2012). Issue brief. Pediatric physician shortages affect access to care. Washington, DC: CHA.; The Lewin Group, Inc. & DMA Health Strategies. (2009).; Carstens, C., Blunt, E., & Warren, B. (2002). 2002 Safety net survey executive summary. Ohio Department of Mental Health.

<sup>xxvi</sup> For example, Hyde (2013) reports that SAMHSA has predicted 12,624 child and adolescent psychologists will be needed by the year 2020, but only 8,312 will be available. Koppelman (2004) finds that the number of these practitioners in the U.S. has plateaued in recent years. More generally, the Lewin Group, Inc. & DMS Health

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Strategies (2009) report that the entire mental health workforce is aging. A majority of current practitioners are over age 50, and half are likely to retire in the next two decades.

<sup>xxvii</sup> American Hospital Association. (2016).

<sup>xxviii</sup> Hyde, P. (2013).

<sup>xxix</sup> Hyde, P. (2013).

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<sup>xxxi</sup> The Annapolis Coalition on the Behavioral Health Workforce. (2007).

<sup>xxxii</sup> Antal, P. (2016).

<sup>xxxiii</sup> Antal, P. (2016).

<sup>xxxiv</sup> According to BLS estimates, the two most prevalent behavioral health positions in elementary and secondary schools in New Hampshire are counselors (820 workers) and registered nurses (470 workers). The two most prevalent behavioral health positions in outpatient mental health and substance abuse centers in New Hampshire are counselors (690 workers) and social workers (190 workers). Approximately 90 percent of the counselors employed in these centers fall under the BLS classification of “Mental Health Counselors,” while the remaining 10 percent are classified as “Substance Abuse and Behavioral Disorder Counselors.” Data are presented for the more common position, Mental Health Counselors. Of employed social workers, 140 (roughly 74 percent) fall under the BLS classification of “Mental Health and Substance Abuse Social Workers” and the remaining 50 (26 percent) fall under the classification of “Child, Family, and School Social Workers.” Data are presented for the more common position, Mental Health and Substance Abuse Social Workers.

<sup>xxxv</sup> U.S. Department of Health and Human Services. (n.d.) U.S. Federal poverty guidelines used to determine financial eligibility for certain federal programs. Retrieved from <https://aspe.hhs.gov/poverty-guidelines>

<sup>xxxvi</sup> Glasmeier, A. (2017). Living wage calculator. Background. Retrieved from <http://livingwage.mit.edu/pages/about>

<sup>xxxvii</sup> U.S. Bureau of Labor Statistics. (2017). Occupational Employment Statistics. 2016 OES research estimates by state and industry. Retrieved from [https://www.bls.gov/oes/current/oes\\_research\\_estimates.htm](https://www.bls.gov/oes/current/oes_research_estimates.htm)

<sup>xxxviii</sup> Ballester, G. (2005). This 2005 Massachusetts study of the broad occupational category of “community health worker” finds that this occupation is “used today as an umbrella term to describe members of the health workforce that function under a multitude of various job titles” (page 7). The study found that job titles which commonly fall under this umbrella include case managers and family support workers.

<sup>xxxix</sup> Antal, P. (2016). In presenting a breakdown of the direct services workforce in 7 New Hampshire CMHC in FY 2014, Antal classifies “case managers” as a category that includes functional family support case managers and staff with waivers (less than BA). See page 7.

<sup>xl</sup> Antal, P. (2016). This finding is based on data collected from 7 of 10 CMHC for FY 2014. Antal gives the rate of employment per 1,000 children for the 254 direct services staff serving 9,494 children that year. This information was used to back into the portion of case managers in the workforce.

<sup>xli</sup> U.S. Bureau of Labor Statistics. (2017). Occupational Outlook Handbook. Retrieved from <https://www.bls.gov/ooh/home.htm>

In the handbook, community health workers are classified under the broad category of “health educators and community health workers”.

<sup>xlii</sup> Hyde, P. (2013).

<sup>xliii</sup> See for example: Hoge, et al. (2013).; Hyde, P. (2013).; Antal, P. (2016).

<sup>xliv</sup> Hoge, et al. (2013).

<sup>xlv</sup> The Lewin Group, Inc. & DMA Health Strategies. (2009).

<sup>xlvi</sup> Huang, L., Macbeth, G., Dodge, J., & Jacobstein, D. (2004). Transforming the workforce in children’s mental health. *Administration and Policy in Mental Health* 32(2): 167-187.

<sup>xlvii</sup> Hyde, P. (2013).

<sup>xlviii</sup> Hyde, P. (2013).

<sup>xliv</sup> Antal, P. (2016).; Miller, P. & Pero Consulting Group, LLC. (2017).

<sup>1</sup> Antal, P. (2016).

<sup>li</sup> Covert, S. (2009). Children’s mental health services in New Hampshire: where we are now, where we need to go, and how to move forward. Concord, NH: Endowment for Health, New Hampshire Department of Health and Human Services, National Alliance on Mental Illness-New Hampshire. Retrieved from [http://www.endowmentforhealth.org/uploads/resources/id13/CMH\\_Services\\_NH.pdf](http://www.endowmentforhealth.org/uploads/resources/id13/CMH_Services_NH.pdf)

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- liv Data retrieved from U.S. Department of Health & Human Services 2016 poverty guidelines, available at <https://aspe.hhs.gov/computations-2016-poverty-guidelines>
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DRAFT



**Frank Edelblut**  
Commissioner

**Jeffery Meyers**  
Commissioner

**STATE OF NEW HAMPSHIRE**

**INTER-AGENCY AGREEMENT (IAA)  
BETWEEN  
THE NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES  
AND  
THE NEW HAMPSHIRE DEPARTMENT OF EDUCATION  
REGARDING  
THE SYSTEM OF CARE FOR CHILDREN'S MENTAL HEALTH**

**I. PURPOSE**

The purpose of this document is to establish an interagency agreement between the NH Department of Health and Human Services and the NH Department of Education in accordance with RSA 135-F:7 to collaboratively develop and implement a System of Care for children's behavioral health, and enhance the ways in which the two agencies work together to realize efficiencies and improvements in services.

**II. SYSTEM OF CARE**

System of Care means an integrated and comprehensive delivery structure for the provision of publicly funded behavioral health services to New Hampshire children and youth.

**III. RESPONSIBILITIES OF THE COMMISSIONER OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

- A. To the extent possible within existing statutory and budgetary constraints, modify the policies and practices of the department of health and human services to establish a system of care.**
- B. Develop a plan for full establishment and maintenance of a system of care. Such plan shall be reviewed and amended annually. It shall include sufficient detail to allow compliance with the reporting requirements of RSA 135-F:6, and shall address at least the following elements:**
  - i. System capacity, including workforce sufficiency.**
  - ii. Federal funding participation, including but not limited to Medicaid waivers and plan amendments.**
  - iii. Changes to statutes, administrative rules, and structure of appropriations, and department policy, practice, and structure.**
  - iv. Projections of cost savings from increased service effectiveness and reductions in costly forms of care and use of such savings to close existing gaps in children's behavioral health services.**

- v. Recommended modifications to law, practice, and policy to prepare for and accommodate the participation of privately funded service providers in the system of care.
- vi. Coordination with the plans and activities of the commissioner of the department of education to implement the system of care.

**IV. RESPONSIBILITIES OF THE COMMISSIONER OF THE DEPARTMENT OF EDUCATION**

- A. To the extent possible within existing statutory and budgetary constraints, modify the policies and practices of the department of education to support establishment of a system of care.
- B. Develop a plan for full support and participation of the department of education in the establishment and maintenance of a system of care by the department of health and human services. Such plan shall be reviewed and amended annually. It shall include sufficient detail to allow compliance with the reporting requirements of RSA 135-F:6, and shall address at least the following elements:
  - i. Development of a multi-tiered system of supports in New Hampshire schools.
  - ii. System capacity, including workforce sufficiency.
  - iii. Federal funding participation, including but not limited to Medicaid waivers and plan amendments.
  - iv. Changes to statutes, administrative rules, and structure of appropriations, and department policy, practice, and structure.
  - v. Projections of cost savings from increased service effectiveness and reductions in costly forms of care and use of such savings to close existing gaps in children's behavioral health services.
  - vi. Coordination with the plans and activities of the commissioner of the department of health and human services to implement the system of care.

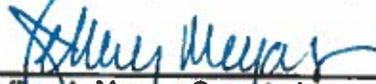
**V. JOINT RESPONSIBILITIES OF THE COMMISSIONERS**

- A. Coordinate a delivery system of behavioral health services across the life span of children, youth and adults with behavioral health needs.
- B. Maximize federal reimbursement and revenue.
- C. Coordinate care and funding among the Departments and their participating agencies.
- D. Assist local education and behavioral health providers by:
  - i. Developing model agreements to be utilized by school districts, other education providers, area agencies, community mental health centers, and other entities participating in the System of Care.
  - ii. Providing technical assistance to support the development of coordinated services by school districts, other education providers, area agencies, community mental health centers, and other entities participating in the System of Care.
- E. Implement the plan to close gaps in the System of Care, as outlined in the annual report submitted in pursuance of 135-F:6.

VI. PERIOD OF AGREEMENT

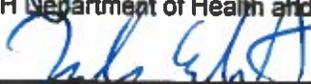
This agreement shall become effective when signed by all parties. The term of the agreement is two years, unless renegotiated sooner. The agreement shall be amended as necessary by mutual agreement of the parties.

Executed this 20th day of November, 2017.



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Jeffrey A. Meyers, Commissioner  
NH Department of Health and Human Services



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Frank Edelblut, Commissioner  
NH Department of Education